DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

Mr. Anthony D. Rodgers
Director
Arizona Health Care Cost Containment System
801 East Jefferson
Phoenix, AZ 85034

Dear Mr. Rodgers:

Thank you for acceptance letter of November 21, 2006 to the State of Arizona's section 1115 demonstration projects (nos. 11-W-00032/09 and 21-W-00009/9) for the five year period beginning October 27, 2006. This letter serves to document the Center of Medicaid and Medicare's (CMS) acceptance of those technical clarifications to the demonstration's waiver list, cost not otherwise matchable authorities (CNOM) and Special Terms and Conditions (STC) as detailed within the letter. CMS agrees that these technical clarifications will help to ensure that the documentation associated with the demonstration extension accurately reflects the historical operation of the State's section 1115 demonstration project. CMS agrees to the following:

- Revising the Freedom of Choice waiver to include a reference for pre-paid inpatient health plans.
- Clarifying the Medicaid CNOM list by:
    - Adding the existing authority to incur expenditures eligible for Federal matching funds to provide Medicaid coverage to individuals with adjusted net countable family income at or below 100 percent of the FPL;
    - Limiting the basis for a person enrolled with a managed care organization to disenroll for cause at any time to issues related to continuity of care;
    - Permitting the State to employ a preadmission screening (PAS) assessment rather than the SSA disability standards to determine persons eligible for long-term care and home and community based services;
    - Permitting the State to restrict the application of the special income limit of 300 percent of the FBR to persons who meet the standard established by the State's PAS assessment regardless of whether the person resides in a hospital, nursing facility or ICF-MR – this includes permitting the State to apply the special income standard as soon as the person meets the standards of the PAS;
    - Permitting the State to exclude parental income for children under the age of 18 who meet the standards of the PAS without regard to whether the child has been out of the home for 30 or more days; however, to the extent that the child has

countable income, post-eligibility treatment of income regulations will apply to that income for children receiving long term care or home and community based services.

CMS recognizes that the State is committed to implementation of an Employer Sponsored Insurance program and the precise parameters of that program have not been finalized the State will be bound by the terms finally approved by CMS on October 27, 2006 in the Special Terms and Conditions. It is also agreed that the "per member – per month" costs reflected in paragraph 66(a)(iii) and the required financial reporting by the State to CMS are effective as of October 1, 2006.

Enclosed are the waiver list, CNOM list and STCs with the prescribed technical clarifications. We would like to thank you and your staff for working with us on this project, and we look forward to continuing our collaborative efforts.

Sincerely,

Clarke Cagey
Director
Division of State Waivers and Demonstrations

Cc: Linda Minamoto
Steven Rubio

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST

NUMBERS: **11-W-00032/09 (Title XIX)**
21-W-00009/9 (Title XXI)

TITLE: **Arizona Medicaid Section 1115 Demonstration**

AWARDEE: **Arizona Health Care Cost Containment System (AHCCCS)**

All Medicaid and State Children's Health Insurance Program requirements expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning October 27, 2006, through September 30, 2011. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

1. Proper and Efficient Administration **Section 1902(a)(4) (42 CFR 438.52, 438.56)**

To permit the State to limit acute care enrollee's and ALTCS enrollees' choice of managed care plans to a single Prepaid Inpatient Health Plan (PIHP) -- Children's Rehabilitative Services Program (CRS) – for the treatment of conditions covered under that program and to permit the State to limit acute care enrollees' choice of managed care plans to a single PIHP – the Arizona Department of Health Services Division of Behavioral Health – for the treatment of behavioral health conditions, as long as enrollees in such plans may request change of primary care provider at least at the times described in Federal regulations at 42 CFR 438.56(c).

To permit the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same PIHP in which he or she was previously enrolled.

To permit the State to restrict the ability to disenroll without cause after an initial 30 day period from a managed care plan.

To permit the state to restrict beneficiary disenrollment based on 42 CFR 438.56(d)(2)(iv), which provides for disenrollment for causes including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs

2. Cost Sharing **Section 1902(a)(14) (42 CFR 447.51 and 447.52)**

To enable the State to charge a premium to parents of ALTCS Medicaid qualified disabled children (under 18 years of age) when the parent's annual adjusted gross income is at or exceeds 400 percent of the FPL.

3. Disproportionate Share Hospital (DSH) Requirements **Section 1902(a)(13)**

To relieve the State from the obligation to make payments for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients in accordance with the provisions for disproportionate share hospital payments that are described in the STCs.

4. Freedom of Choice **Section 1902(a)(23)**
(42 CFR 431.51)

To enable the State to restrict freedom of choice of providers by furnishing benefits through enrollment of eligible individuals in managed care organizations and/or Prepaid Inpatient Health Plans.

5. Drug Rebate **Section 1902(a) (54)**
(42 CFR 456.700 through 456.725)

To enable the State to receive payment for FFS and PIHP outpatient drugs without having to comply with the requirements of section 1927(g) of the Act pertaining to drug use review.

6. Retroactive Eligibility **Section 1902(a) (34)**
(42 CFR 435.914)

To enable the State to waive the requirement to provide medical assistance for up to 3 months prior to the date that an application for assistance is made for AHCCCS.

7. Amount, Duration, Scope of Services **Section 1902(a)(10)(B)**
(42 CFR 440.240 and 440.230)

To enable the State to offer different or additional services to some categorically eligible or medically needy individuals, than to other eligible individuals, based on differing care arrangements in the Spouses as Paid Caregivers Program.

To permit managed care organizations (MCOs) and PIHPs to provide additional or different benefits to enrollees, that may not be available to other eligible individuals.

8. Estate Recovery **Section 1902(a)(18)()**
(42 CFR 433.36)

To enable the State to exempt from estate recovery as required by section 1917(b), the estates of acute care enrollees age 55 or older who receive long-term care services.

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9. Eligibility Based on Institutional Status **Section 1902(a)(10)(A)(ii)(V)**
(42 CFR 435.217 and 435.236)

To the extent that the State would be required to make eligible individuals who are in an acute care hospital for greater than 30 days and who do not meet the level of care standard for long term care services.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBERS: **11-W-00032/09**
21-W-00009/9

TITLE: **Arizona Medicaid Section 1115 Demonstration**

AWARDEE: **Arizona Health Care Cost Containment System (AHCCCS)**

Medicaid Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of this demonstration, be regarded as matchable expenditures under the State's Medicaid State plan:

I. Expenditures Related to Administrative Simplification and Delivery Systems

1. Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A) of the Act specified below. AHCCCS's managed care plans participating in the demonstration will have to meet all the requirements of section 1903(m) except the following:
   a Section 1903(m)(2)(A)(i), but only insofar as the provisions of section 1903(m)(1)(A)(i) would otherwise preclude Native Americans from having a choice to enroll in either Indian Health Service facilities or AHCCCS plans.
   b Section 1903(m)(2)(A)(vi) insofar as it requires compliance with requirements in section 1932(a)(4) and Federal regulations at 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period after enrollment to disenroll without cause that would be longer than 30 days.
   c Section 1903(m)(2)(A)(xii) but only insofar as it requires the State to comply with section 1932(a)(3) and Federal regulations at 42 CFR 438.52 to offer a choice of at least two managed care organizations (MCOs) in the Arizona Long Term Care Service (ALTCS) and Comprehensive Medical and Dental Program (CMDP) programs, as long as enrollees in such plans have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in Federal regulations at 42 CFR 438.56(c). Notwithstanding this authority, the State must offer a choice of at least two MCOs to elderly and physically disabled individuals in Maricopa County.
   d Section 1903(m)(2)(H) and Federal regulations at 42 CFR 438.56(g) but only insofar as to allow the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same managed care plan from which the individual was previously enrolled.

2. Expenditures that would have been disallowed under section 1903(u) of the Act and Federal regulations at 42 CFR 431.865 based on Medicaid Eligibility Quality Control findings.

3. Expenditures for outpatient drugs which are not otherwise allowable under section 1903(i)(10).

4. Expenditures for direct payments to Critical Access Hospitals for services provided to AHCCCS enrollees in the Acute Care and ALTCS managed care programs that are not otherwise allowable under Federal regulations at 42 CFR 438.60.

5. Expenditures for inpatient hospital and long-term care facility services, other institutional and non-institutional services (including drugs) provided to AHCCCS fee-for-service beneficiaries, that exceed the amounts allowable under section 1902(a)(30)(A) (Federal regulations at 42 CFR 447.250 through 447.280, 447.300 through 447.334) but are in accordance with STC #53 entitled "Applicability of Fee-for-Service Upper Payment Limit."

6. Expenditures for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients but are not allowable under sections 1902(a)(13)(A) and 1923 of the Act, but are in accordance with the provisions for DSH payments that are described in the STCs.

II. Expenditures Related to Expansion of Existing Eligibility Groups based on Eligibility Simplification

7. Expenditures related to:

    a. Medical assistance furnished to ALTCS enrollees who are eligible only as a result of the disregard from eligibility of income currently excluded under section 1612(b) of the Act, and medical assistance that would not be allowable for some of those enrollees but for the disregard of such income from post-eligibility calculations.
    b. Medical assistance furnished to ALTCS enrollees who are financially eligible with income equal to or less than 300 percent of the Federal Benefit Rate and who meet the criteria in the preadmission screening instrument (PAS) regardless of whether or how long they actually have been in an institutional setting; that is, notwithstanding the requirements of 42 CFR 435.540 (regarding disability determination in accordance with SSI standards) and 435.662 (regarding residence in an institutional setting for at least 30 days).
    c. Medical assistance furnished to some dependent children or spouses who qualify for ALTCS based on a disregard of income and resources of legally responsible relatives or spouses during the month of separation from those relatives or spouses.
    d. Medical assistance furnished to individuals who are eligible as Qualified Medicare Beneficiary, Special Low Income Beneficiary, Qualified Individuals-

1, or Supplemental Security Income Medical Assistance Only (SSI MAO) beneficiaries based only on a disregard of in-kind support and maintenance (ISM).

e. Medical assistance furnished to individuals who are eligible based only on an alternate budget calculation for ALTCS and SSI-MAO income eligibility determinations when spousal impoverishment requirements of section 1924 of the Act do not apply or when the applicant/recipient is living with a minor dependent child.
f. Medical assistance furnished to individuals who are eligible in SSI-MAO groups based only on a disregard of resources in the form of insurance and burial funds, household goods, mineral rights, oil rights, timber rights, and personal effects.
g. Medical assistance furnished to individuals who are eligible only based on the disregard of interest and dividend from resources, and are in the following eligibility groups:

    i. The Pickle Amendment Group under 42 CFR 435.135;
    ii. The Disabled Adult Child under section 1634(c);
    iii. Disabled Children under section 1902(a)(10)(A)(i)(II); and
    iv. The Disabled Widow/Widower group under section 1634(d)

h. Medical assistance furnished to ALTCS enrollees under the eligibility group described in section 1902(a)(10)(A)(ii)(V) of the Act that exceeds the amount that would be allowable except for a disregard of interest and dividend from the post-eligibility calculations.
i. Medical assistance provided to individuals who would be eligible but for excess resources under the "Pickle Amendment," section 503 of Public Law Number 94-566; section 1634(c) of the Act (disabled adult children); or section 1634(b) of the Act (disabled widows and widowers).
j. Medical assistance that would not be allowable but for the disregard of quarterly income totaling less than $20 from the post-eligibility determination.

III. Expenditures Related to Benefits

8. Expenditures associated with the provision of Home & Community-Based Services (HCBS) to disabled individuals under the age of 18 with income levels up to 300 percent of the SSI income level without considering parental income as otherwise required by section 1902(a)(10)(C)(i) and 42 CFR 435.602.

9. Expenditures associated with the provision of Home & Community-Based Services (HCBS) to individuals with income levels up to 300 percent of the SSI income level or are enrolled in the ALTCS Transitional program and who meet the criteria in the preadmission screening instrument (PAS) regardless of whether or how long they actually have been in an institutional setting.

10. Expenditures for family planning services for up to 24 months, with an annual re-determination at 12 months, for uninsured women that have lost Medicaid pregnancy coverage within the last year at the conclusion of their 60-day postpartum period and who are not otherwise eligible for Medicare, Medicaid (including other components of this section 1115 demonstration), State Children's Health Insurance Program, or have other public or creditable private health insurance coverage (Family Planning Extension Program).

11. Expenditures for services to an AHCCCS enrollee age 21-64 residing in an Institution for Mental Disease for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days. The proportion of total State expenditures that will be recognized under this demonstration will be phased out, in accordance with clause 55 of the Terms and Conditions, and will expire entirely in fiscal year 2009.

12. Expenditures for demonstration caregiver services provided by spouses of the demonstration participants.

13. Expenditures to provide coverage through employer-sponsored insurance for eligible employees of small businesses and with family income below 200 percent of the Federal poverty level (FPL) that would not otherwise be allowable because it is not cost effective.

14. Expenditures to provide Medicaid coverage to individuals who have medical bills incurred by the family unit sufficient to reduce their adjusted net countable family income to 40 percent or less of the FPL and who are not otherwise eligible for Medicaid.

15. Expenditures to provide Medicaid coverage to individuals with adjusted net countable family income at or below 100 percent of the FPL who are not otherwise eligible for Medicaid.

16. Expenditures to provide coverage to parents of Medicaid or SCHIP children with adjusted net countable income from 100 percent up to and including 200 percent of the FPL who are not otherwise eligible for Medicare, Medicaid, or SCHIP and for whom the State may claim title XIX funding when title XXI funding is exhausted.

Medicaid Requirements Not Applicable

Medicaid populations made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are not subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this Demonstration. The following Medicaid requirements will not apply to such demonstration populations:

1. Cost Sharing — **Section 1902(a)(14) (42 CFR 447.50 through 447.56)**

To enable the State to impose cost sharing, to the extent necessary, for parents of Medicaid or SCHIP children with adjusted net countable income from 100 up to and including 200 percent of the FPL, for those in the employer- sponsored insurance program individuals without dependent children between 0-100 percent of the FPL, and for the MED expansion group.

2. Amount, Duration, Scope of Services **Section 1902(a)(10)(B) (42 CFR 440.210)**

To enable the State to modify the Medicaid benefits package for those in the employer-sponsored insurance program in order to offer a different benefit package than would otherwise be required under the State plan. This authority is granted only to the extent necessary to allow those in the employer-sponsored insurance plan to receive coverage through a private or employer-sponsored insurance plan, which may offer a different benefit package than that available through the State plan.

3. Retroactive Coverage **Section 1902(a)(34) (42 CFR 435.914)**

Individuals who enroll in the employer-sponsored insurance program and parents of Medicaid or SCHIP children with adjusted net countable income from 100 up to and including 200 percent of the FPL, individuals without dependent children between 0-100 percent of the FPL, and for the MED expansion group will not be retroactively eligible.

4. Providing Medical Assistance **Section 1902(a)(10)**

To enable the State to deny eligibility for medical assistance to parents of Medicaid or SCHIP children who have voluntarily terminated health insurance coverage during the 3 month period prior to application and who have adjusted net countable income from 100 up to and including 200 percent of the FPL.

Medicaid Requirements Not Applicable to the Family Planning Extension Program:

1. **Amount, Duration, and Scope (Comparability)** **Section 1902(a)(10)(B) (42 CFR 440.240)**

To the extent necessary to allow the State to offer the demonstration population a benefit package consisting only of CMS-approved family planning services.

2. **Early and Periodic Screening, Diagnostic and Treatment (EPSDT)** **Section 1902(a)(43)(A) (42 CFR 440.40 and 441.50 through 441.62)**

The State will not furnish or arrange for EPSDT services to the demonstration population.

3. **Retroactive Eligibility** **Section 1902(a)(34) (42 CFR 435.914)**

   Individuals in the Family Planning Extension program will not be retroactively eligible.

4. **Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics** **Section 1902(a)(15) (42 CFR 447.371)**

   To enable the State to establish reimbursement levels to these clinics that would compensate them solely for family planning services.

5. **Eligibility Re-determination** **Section 1902(a)(19) (42 CFR 435.916)**

   To enable the State to exempt women, who are eligible for the family planning program by virtue of losing Medicaid eligibility at the conclusion of their 60-day postpartum period (SOBRA women), from reporting changes in income during their 12-month eligibility period.

SCHIP Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A), State expenditures described below, shall, for the period of this project and to the extent of the State's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the State's title XXI plan. All requirements of title XXI will be applicable to such expenditures for the demonstration populations described below, except those specified below as not applicable to these expenditure authorities.

1. **Childless Adults**. Subject to STC #38, expenditures to provide coverage to uninsured individuals over age 18 with adjusted net countable family income between 40 percent and 100 percent of the FPL, who are childless adults, and who are not otherwise eligible for Medicare, Medicaid (except for demonstration title XIX expansion groups), or have other creditable health insurance coverage.
2. **Parents.** Subject to STC #38, expenditures to provide health care coverage consistent with the requirements of section 2103 to uninsured individuals whose adjusted net countable family income above 100 percent of the FPL up to and including 200 percent of the FPL, who are parents of children enrolled in the Arizona Medicaid or title XXI program, and who are not otherwise eligible for Medicare, Medicaid, or have other creditable health insurance coverage.
3. **Employer-Sponsored Insurance**. Expenditures to provide coverage through employer-sponsored insurance for employees of small businesses and with family income below 200 percent of the FPL and who are not eligible for Medicare or Medicaid should CMS approve the use of title XXI funds.

SCHIP Requirements Not Applicable to SCHIP Expenditure Authorities

1. **General Requirements, Eligibility, and Outreach** — **Section 2102 (42 CFR 457.90)**

   The State child health plan does not have to reflect the demonstration population, and eligibility standards do not have to be limited by the general principles in section 2102(b) of the Act. The State must perform eligibility screenings to ensure the demonstration populations do not include individuals otherwise eligible for Medicare, Medicaid (except for childless adults described in SCHIP CNOM #1) or have other creditable health insurance coverage.

2. **Federal Matching Payment and Family Coverage Limits** — **Section 2105 (42 CFR 457.618)**

   The State will be allowed to receive Federal matching payment for the Demonstration Populations without the restrictions described in section 2105(c)(2) that would otherwise require the State to cover populations other than targeted low-income children under the 10 percent administrative cap. This provision does not waive the 10 percent administrative cap for title XXI expenditures. It does, however, allow the State to cover a population besides children outside of a health service initiative and the 10 percent administrative cap, which would be the customary vehicle for covering a population other than targeted low-income children.

3. **Annual Reporting Requirements** — **Section 2108 (42 CFR 457.700 through 457.750)**

   The State does not have to meet the annual reporting requirements (the submission of an annual report into the State Annual Report Template System of section 457.750 for the demonstration populations. The State will report on issues related to the demonstration populations in quarterly and annual reports and enrollment data through the Statistical Enrollment Data System.

4. **Cost Sharing** — **Section 2103(e) (42 CFR 457.530 through 457.560)**

   Rules governing cost sharing under section 2103(e) of the Act shall not apply to the demonstration populations to the extent necessary to impose cost sharing for parents, childless adults, and for those in the employer- sponsored insurance program.

5. **Restrictions on Coverage and Eligibility To Targeted Low-Income Children** — **Section 2103 and 2110**

Coverage and eligibility for the demonstration populations are not restricted to targeted low-income children.

6. **Benefit Package Requirements** **Section 2103**

To permit the State to offer a benefit package for the employer-sponsored insurance program that does not meet the requirements of section 2103 at Federal regulations at 42 CFR 457.410(b)(1).

SPECIAL TERMS AND CONDITIONS
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

MEDICAID SECTION 1115 DEMONSTRATION

NUMBER: 11-W-00032/09
21-W-00009/9

TITLE: Arizona Health Care Cost Containment System -- AHCCCS, A Statewide Approach of Cost Effective Health Care Financing

AWARDEE: Arizona Health Care Cost Containment System

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Arizona's section 1115(a) Medicaid demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the State of Arizona and the Centers for Medicare & Medicaid Services (CMS). This Demonstration is approved for a 5-year period, from October 27, 2006, through September 30, 2011. The STCs set forth below and the lists of waivers and expenditure authorities are incorporated in their entirety into the letter approving the Demonstration. The STCs are effective October 14, 2006, unless otherwise specified. All previously approved STCs are superseded by the STCs set forth below.

The STCs have been arranged into the following subject areas: Program Overview; General Program Requirements; General Reporting Requirements; Demonstration Program Design Inclusive of Eligibility; Benefits and Enrollment; Cost-Sharing for Acute Care Services; Long Term Care Services; Health Insurance Flexibility & Accountability (HIFA); Family Planning; Institution for Mental Disease Phase-Down; Evaluation; General Financial Requirements; Monitoring Budget & Allotment Neutrality: and a Timeline of State Deliverables.

II. PROGRAM OVERVIEW

Until 1982, Arizona was the only State that did not have a Medicaid program under title XIX. In October 1982, Arizona implemented the AHCCCS as a section 1115 demonstration project.

From October 1982 until December 1988, AHCCCS covered only acute care services, except for 90-day post-hospital skilled nursing facility coverage. In November 1988, a 5-year extension of the program was approved (later amended to 6 years) by CMS to allow Arizona to implement a capitated long term care (LTC) program for the elderly and physically disabled (EPD) and the developmentally disabled (DD) populations. The Arizona Long Term Care System (ALTCS) began in December 1988 for DD members and in January 1989 for EPD members. It is administered as a distinct program from the acute care program.

On October 1, 1990, AHCCCS began phasing in comprehensive behavioral health services, beginning with coverage of seriously emotionally disabled children under the age of 18 years who require residential care. Over the next 5 years, behavioral health coverage was extended to all Medicaid-eligible persons.

In November of 2000, Arizona voters approved Proposition 204, which expanded income limits to 100 percent of the Federal poverty level (FPL) for full acute care Medicaid. This expansion was approved in January 2001 by CMS and included coverage up to 100 percent for traditional Temporary Assistance for Needy Families and SSI populations as well as adults without dependent children in addition to the Medical Expense Deduction (MED) program for Medicaid-eligible persons.

In 2001 the AHCCCS program submitted a HIFA amendment and the State received permission from CMS to use title XXI funds to expand coverage to two populations: (1) adults over age 18 without dependent children and with adjusted net family income at or below 100 percent of the FPL, and (2) individuals with adjusted net family income above 100 percent FPL and at or below 200 percent FPL who are parents of children enrolled in the Arizona Medicaid or State Health Insurance Program (SCHIP) programs, but who themselves are not eligible for either program. Children are enrolled in the Arizona SCHIP program, known as "KidsCare."

On March 13, 2006, Arizona submitted a "Waiver Renewal Proposal" for its entire section 1115 demonstration. This renewal is significant in that it is the first time that the ALTCS portion of the demonstration is required to establish budget neutrality.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State agrees that it shall comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the award letter of which these terms and conditions are part, shall apply to the Demonstration.

3. **Compliance with the Deficit Reduction Act of 2005**. For the current extension period of this demonstration, the foregoing requirement shall apply to all applicable regulation and policy issued by CMS, with respect to the Deficit Reduction Act (DRA) signed into law on February 8, 2006, including but not limited to the documentation of citizenship requirements contained in 1903(x) of the Social Security Act (the Act).

4. **Changes in Law.** The State must, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid and SCHIP programs that occur after the approval date of this Demonstration, unless the change is made to a requirement that has been explicitly waived.

5. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy Statements.** To the extent that a change in Federal law impacts State Medicaid spending on program components included in the Demonstration, CMS shall incorporate such changes into a modified budget neutrality expenditure cap for the demonstration. The modified budget neutrality expenditure cap would be effective upon implementation of the change in the Federal law. The growth rates for the budget neutrality baseline are not subject to this STC. If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

6. **State Plan Amendments.** The State shall not be required to submit title XIX or title XXI State plan amendments for changes to any populations covered solely through the Demonstration. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required except as otherwise noted in these STCs.

7. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment limitations, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, supplemental payment programs, budget and allotment neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. The state must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and Federal financial participation (FFP) may not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 8 below. This paragraph does not apply to changes that are subject to the State plan amendment process. However, copies of all State plan amendments must be submitted to the Demonstration Project Officer as well as to the Regional Office.

8. **Demonstration Amendment Process:** Demonstration amendment requests must be submitted to CMS for approval no later than 120-days prior to the date of implementation and may not be implemented until approved. Amendment requests must be reviewed by the Federal Review Team and must include, but are not limited to, the following:
   a) An explanation of the public process used by the State to reach a decision regarding the requested amendment;
   b) A data analysis that identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis shall include current "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;
   c) An analysis of the impact on allotment neutrality if the amendment affects a title XXI HIFA population
   d) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
   e) A description of how the evaluation design shall be modified to incorporate the amendment provisions.

9. **Extension of the Demonstration**. If the State intends to extend the Demonstration beyond the period of approval granted herein the State is responsible for reviewing, complying and adhering to the timeframes and reporting requirements as set forth in section 1115 (e) the Act and the STCs. During the 6-month period ending 1-year before the date this extension is scheduled to expire (September 30, 2011), the State must submit to CMS written notice of the State's intent to extend the Demonstration. Regardless of the authority for the extension, the State must submit to CMS no later than September 30, 2010, a complete extension application, including any proposed Demonstration modifications, and complete budget and allotment neutrality data.

10. **Demonstration Phase-Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State shall submit a phase-out plan to CMS at least 6-months prior to initiating phase-out activities. The State may also submit an extension plan on a timely basis to prevent disenrollment of Demonstration enrollees. Nothing herein shall be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6-months when such action is necessitated by emergent circumstances. The phase-out plan and extension plan are subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

11. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in STC #10, during the last 6 months of the Demonstration, the enrollment of individuals who would not be eligible for Medicaid under the current Medicaid State plan shall not be permitted. Enrollment may be suspended if CMS notifies the State in writing that the waiver will not be renewed.

12. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the State has materially failed to comply with the terms of the project. CMS shall promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date. If CMS suspends or terminates the Demonstration, CMS and the State will agree on a phase-out plan.

13. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.

14. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of titles XIX or XXI. CMS shall promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and shall afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, CMS and the State will agree on a phase-out plan and

effective date. Upon the effective date, FFP is limited to normal closeout costs associated with terminating the Demonstration including services and administrative costs of disenrolling participants.

15. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

16. **Public Notice and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (1994) when any program changes to the Demonstration, including, but not limited to, those referenced in paragraph 7, are proposed by the State.

17. **Compliance with Managed Care Regulations.** The State must comply with the managed care regulations at 42 CFR section 438 et. seq., except as expressly waived or referenced in the expenditure authorities incorporated into the STCs. These managed care regulations apply equally to all managed care organization (MCO) and Prepaid Inpatient Health Plan (PIHP) contracts AHCCCS holds, including managed care contracts with other State agencies. Capitation rates, must be developed and certified as actuarially sound in accordance with Federal regulations at 42 CFR section 438.6(c).

18. **Federal Funds Participation.** No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter. No FFP is available for this Demonstration for Medicare Part D drugs.

IV. GENERAL REPORTING REQUIREMENTS

19. **General Financial Requirements.** The State shall comply with all general financial requirements under title XIX and title XXI.

20. **Reporting Requirements Relating to Budget and Allotment Neutrality.** The State shall comply with all reporting requirements for monitoring budget and allotment neutrality set forth in this Agreement.

21. **Budget Neutrality Information.** For each quarter, the State will correctly report expenditures and member months that are subject to budget neutrality. Where data are incorrect and upon the request of CMS, the State must submit corrected budget neutrality data.

22. **Encounter Data.** Any MCOs or PIHPs in the Demonstration shall be responsible for the collection of all data on services furnished to enrollees through encounter data or other methods as specified by the State, and the maintenance of these data at the plan level. The State shall, in addition, develop mechanisms for the collection, reporting, and analysis of these data (which should at least include all inpatient hospital and physician services), as well as a process to validate that each plan's encounter data are timely, complete and accurate.

The State will take appropriate actions to identify and correct deficiencies identified in the collection of encounter data. The State shall have contractual provisions in place to impose financial penalties if accurate data are not submitted in a timely fashion.

23. **Encounter Data Validation Study for New MCOs or PIHPs.** If the State contracts with new MCOs or PIHPs, the State shall conduct a validation study 18 months after the effective date of the contract to determine completeness and accuracy of encounter data. The initial study shall include validation through a sample of medical records of Demonstration enrollees.

24. **Submission of Encounter Data.** The State shall submit encounter data to the Medicaid Statistical Information System (MSIS) system as is consistent with Federal law and section VIII of this document. The State must assure that encounter data maintained at MCOs or PIHPs can be linked with eligibility files maintained at the State.

25. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, MCO operations (such as contract amendments and rate certifications), health care delivery, enrollment, cost sharing, family planning issues, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

26. **Quarterly Reports.** The State shall submit progress reports in a format agreed upon by CMS and the State no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports shall include, but not be limited to (Attachment A – Quarterly Report Guidelines):
    a) A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, health plan financial performance that is relevant to the Demonstration, the benefit package, and other operational issues;
    b) Action plans for addressing any policy and administrative issues identified;
    c) The quarterly reports must also include at least enrollment data, member month data, and budget neutrality monitoring tables.
    d) The number of individuals enrolled in the family planning extension program at the end of the quarter, as well as the number of individuals receiving services during the prior quarter;
    e) HIFA data as required by paragraph 38(f) of this Agreement as well as information on any issues which arise in conjunction with the Employer Sponsored Insurance (ESI) portion of the program, including but not limited to enrollment, quality of care, grievances, and other operational issues; and
    f) Evaluation activities.

27. **Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, the status of the collection and verification of encounter data and policy and administrative difficulties in the operation of the Acute Care, ALTCS, HIFA, ESI and Family Planning components of the Demonstration. The State shall submit the draft annual report no later than 120-days after the end of each operational year. Within 30-days of receipt of comments from CMS, a final annual report shall be submitted.

28. **Final Report.** The State shall submit a final report pursuant to the requirements of section 1115 of the Act.

29. **Contractor Reviews**. The State will forward summaries of the financial and operational reviews that the Arizona Department of Health Services/ Behavioral Health Services (ADHS/BHS) completes on the Regional Behavioral Health Authorities (RBHAs), as well as summaries of reviews that the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) performs on its subcontracting MCOs. The State will also forward summaries of the financial and operational reviews that AHCCCS completes on the Children's Rehabilitative Services Program (CRS) at the Arizona Department of Health Services (ADHS) as well as the Comprehensive Medical and Dental Program (CMDP) at the Arizona Department of Economic Security (DES).

30. **Contractor Quality**. AHCCCS will require the same level of quality reporting for DES/DDD, DES/CMDP, ADHS/BHS and ADHS/CRS as for Health Plans and Program Contractors, subject to the same time lines and penalties.

31. **Contractor Disclosure of Ownership**. Before contracting with any provider of service, the State will obtain from the provider full disclosure of ownership and control and related party transactions, as specified in sections 1124 and 1902(a)(38) of the Act. No FFP will be available for providers that fail to provide this information.

V. ELIGIBILITY, ENROLLMENT, BENEFITS & COST SHARING

32. **Eligibility:** Arizona covers all of the mandatory Medicaid eligibility groups, 12 optional groups and 4 expansion groups. Mandatory and optional State plan groups described below are subject to all applicable Medicaid laws and regulations except as expressly waived. Those groups made eligible by virtue of the expenditure authorities expressly granted in this Demonstration are not subject to Medicaid laws or regulations except as specified in the STCs and waiver and expenditure authorities for this Demonstration. The criteria for Arizona eligibility groups are as follows (Table 1):

Table 1 – Demonstration Groups

Description	Program	Social Security Act Cite	42CFR Cite
MANDATORY TITLE XIX COVERAGE GROUPS Families and Children			

Description	Program	Social Security Act Cite	42CFR Cite
1931 (Title IVA program that was in place in July 1 996) including: • pregnant women with no other eligible children (coverage for third trimester) • persons 18 years of age, if a full-time student • family with unemployed parent	AACP	1902(a)(10)(A)(i)(I)	435.110
Twelve months continued coverage (transitional medical assistance) 1931 ineligible due to increase in income from employment or work hours or loss of "income disregard."	AACP	1902(a)(52) 1902(e)(l) 1925(a)(b)(c)	435.112
1931 Extension-Extension of MA when child or spousal support collection results in 1931 ineligibility. (4 months continued coverage)	AACP	408(a)(11)(B) 1902 (a) (10) (A) (i) (I) 1931 (c)	435.115
MANDATORY TITLE XIX COVERAGE GROUPS Pregnant Women, Children, and Newborns			
Qualified pregnant women who: • would be AFDC eligible if child were born and • meet AFDC income & resource criteria	AACP	1902(a)(10)(A)(i)III 1905(n)	435.116
"S.O.B.R.A. WOMEN & INFANTS" Pregnant women & infants under age 1 with incomes less than or equal to 133% FPL. (optional group extends coverage up to 140% FPL for infants under age 1)	AACP ALTCS	1902(a)(10)(A)(i)(IV) 1902(l)(1)(A)	
"S.O.B.R.A. CHILDREN" Children age 1+ but not yet 6 with incomes at or below 133% FPL.	AACP ALTCS	1902(a)(10)(A)(i)(VI) 1902(l)(1)(C)	
"S.O.B.R.A. CHILDREN" Children age 6+ but not yet 19, born after 9-30-83, with income less than or equal to 100% FPL.	AACP ALTCS	1902(a)(10)(A)(i)(VII) 1902(l)(1)(D)	
"DEEMED CATEGORICAL NEWBORNS" Children born to a woman who was eligible and received Medicaid on the date of the child's birth. Children living with their mothers are eligible for 1 year as long as mothers are eligible or would be eligible if pregnant.*	AACP	1902(e)(4)	435.117
MANDATORY TITLE XIX COVERAGE GROUPS Qualified Family Members			
Qualified members of family with unemployed principal wage earner (persons who would be eligible if state did not limit number of months AFDC-UP cash was available).	AACP	1902(a)(10)(A)(i) 1905(m)(l)	435.119
MANDATORY TITLE XIX COVERAGE GROUPS Aged, Blind, and Disabled			
All SSI cash recipients: aged, blind or disabled persons	AACP ALTCS	1902(a)(10)(A)(i)(II)	435.120

Description	Program	Social Security Act Cite	42CFR Cite
Qualified severely impaired working blind or disabled persons < 65 who were: a) receiving Title XIX, SSI or state supplement under 1619(a); or b) eligible for Medicaid under 1619(b) in 6/87	AACP	1902(a)(10)(A)(i)(II) 1905(q)	435.120
"DAC" Disabled adult child (age 18+) who lost SSI by becoming OASDI eligible (i.e., due to blindness or disability that began before age 22) or due to increase in amount of child's benefits.	AACP	1634(c)	
SSI cash or state supplement ineligible for reasons prohibited by Title XIX.	AACP ALTCS		435.122
SSA Beneficiaries who lost SSI or state supplement cash benefits due to cost of living adjustment (COLA) increase in Title II benefits	AACP		435.135
Disabled widow/widower who lost SSI or state supplement due to 1984 increase in OASDI caused by elimination of reduction factor in PL 98-21. (person must apply for this by 7/88)	AACP	1634(b)	435.137
Disabled widow/widower (age 60-64 and ineligible for Medicare Part A) who lost SSI or state supplement due to early receipt of Social Security benefits.	AACP	1634(d)	435.138
"DC Children" Children under the age of 18 who were receiving SSI Cash on 8/26/96 and would continue to be eligible for SSI Cash if their disability met the childhood definition of disability that was in effect prior to 8/26/96.	AACP	1902(a)(10)(A)(i)(II)	
MANDATORY TITLE XIX COVERAGE GROUPS Adoption Assistance and Foster Care Children			
Children in adoption subsidy/foster care Title IV-E programs	AACP ALTCS	473(b)(l) 1902(a)(10)(A)(i)(I)	435.145
MANDATORY TITLE XIX COVERAGE GROUPS Special Groups			
"POSTPARTUM" Title XIX eligible women who apply on or before pregnancy ends, (continuous coverage through the month in which the 60th day postpartum period ends)	AACP	1902(e)(5) 1902(e)(6)	435.170
OPTIONAL TITLE XIX COVERAGE GROUPS			
Description	**Program**	**Social Security Act Cite**	**42CFR Cite**
"210 GROUP" Persons who meet AFDC, SSI or state supplement income & resource criteria.	AACP ALTCS Case Management	1902(a)(10)(A)(ii)(I)	435.210
“211 GROUP" Persons who would be eligible for cash assistance except for their institutional status.	ALTCS	1902(a)(10)(A)(ii)(IV)	435.211
"GUARANTEED ENROLLMENT" Continuous coverage for persons enrolled in AHCCCS Health Plans who lose categorical eligibility prior to 6 months from enrollment. (5 full months plus month of enrollment)	AACP	1902(e)(2)	435.212
"S.O.B.R.A. Infants” infants with incomes between the 133% FPL mandatory group maximum and a 140% FPL optional state maximum.	AACP ALTCS	1902(a)(10)(A)(ii)(IX)	

Description	Program	Social Security Act Cite	42CFR Cite
Pregnant women, including postpartum, who maintain eligibility without regard to changes in income.	AACP	1902(e)(6)	
"HCBS GROUP" Persons receiving HCBS under a waiver with incomes < or equal to 300% of the Federal benefit rate (FBR).	ALTCS	1902(a)(10)(A)(ii)(VI)	435.217
"State Adoption Subsidy" Children who receive a state adoption subsidy payment.	AACP	1902(a)(10)(ii)(VIII)	435.227
"236 GROUP" Persons in medical institutions for 30 consecutive days who meet state-set income level of < or equal to 300% of FBR.	ALTCS	1902(a)(10)(A)(ii)(V)	435.236
"Freedom to Work" Basic Coverage Group – individuals aged 16-64 with a disability who would be eligible, except for earnings, for SSI up to and including 250% of FPL.	AACP ALTCS	1902(a)(10)(A)(ii)(XV)	
"Freedom to Work" Medical Improvement Group – employed individuals aged 16-64 with a medically improved disability up to and including 250% of FPL.	AACP ALTCS	1902(a)(10)(A)(ii)(XVI)	
Women under 65 who need treatment for breast or cervical cancer, and not otherwise eligible for Medicaid.	AACP	1902(a)(10)(A)(ii)(XVIII)	
Children who have aged out of foster care at 18 up to age 21	AACP	1902(a)(10)(A)(ii)(XVII)	
1931 Expansion-Income Greater than 36% FPL and less than or equal to 100% FPL.	AACP		
SSI-MAO Expansion (Optional 210 Group)- aged, blind, or disabled individuals with income greater than 100% FBR and less than or equal to 100% FPL.	AACP	Arizona State Plan	
TITLE XIX AND XXI EXPANSION GROUPS			
Description	**Program**	**Reference**	
Individuals with adjusted net countable income at or below 100% FPL who are not otherwise eligible for Medicaid.	AACP	ARS 36-2901.01	
Uninsured parents of Medicaid or SCHIP children with family income from 100% up to and including 200% of the FPL for whom the State is claiming Title XXI funding.	AACP	2006 Ariz. Sess. Laws, Ch. 331. §32	
AHCCCS eligible women who lose SOBRA eligibility at 60 days postpartum and who are not otherwise eligible for Medicare or Medicaid (up to 24 months following the postpartum period).**	Family Planning	ARS 36-2907.04	
Medical Expense Deduction – Individuals, couples, or families whose income exceeds the Medicaid limits may be eligible after deducting their medical expenses from their income.	AACP	ARS 36-2901.04	

*Arizona's 1115 Waiver provides the authority to waive some of the provisions.

** A phase down of individuals currently covered with other insurance will occur pursuant to STC #39.

33. **Arizona Acute Care Program (AACP)**. The AACP is a statewide, managed care system which delivers acute care services through prepaid, capitated MCOs that AHCCCS calls "Health Plans." Most Health Plan contracts are awarded by Geographic Service Area (GSA), which is a specific county or defined grouping of counties designated by AHCCCS within which a Contractor provides, directly or through subcontract, covered health care to members enrolled with that Contractor. AACP enrollees receive most Medicaid-covered services through the Health Plans, but receive behavioral health services and certain specialty care services for children eligible under the CRS Program on a "carve-out" basis through separate PIHP contracts with the ADHS.
    a. **AACP Eligibility –** Those Groups are identified in paragraph 32 Table 1
    b. **Enrollment** - The Arizona DES processes applications and determines acute care Medicaid eligibility for children, pregnant women, families and non-disabled adults under the age of 65 years and the MED population. The Social Security Administration determines eligibility for the Supplemental Security Income (SSI) cash-related groups, and AHCCCS determines eligibility for the SSI- related aged and disabled groups, Medicare Savings Programs, women diagnosed with breast or cervical cancer, Freedom to Work recipients, and parents of children eligible for title XIX or XXI. Individuals determined eligible must then select and enroll in a Health Plan, or they will be auto-assigned by the AHCCCS administration.
    c. **Benefits** – As outlined in Tables 2 and 3 and subject to limitations set forth in the existing State plan.

Table 2 – AACP Acute Care

Benefit	**Title XIX**		**Title XXI**
Age	< 21 yrs	≥ 21 yrs	< 19 yrs
Audiology	x	x	x
Behavioral Health	See Table 3		
Breast Reconstruction after Mastectomy	x	x	x
Case Management (Administrative)	x	x	x
Chiropractic Services	x		x
Cochlear Implants	x	x	x
Dental Services			
Emergency Dental Services	x	x	x
Medically Necessary Dentures	x	x	x
Preventive & Therapeutic	x		x
Dialysis	x	x	x
Emergency Services-Medical	x	x	x
Eye Examination / Optometry			
Emergency Eye Exam	x	x	x
Vision Exam / Prescriptive Lenses	x		x
Lens Post Cataract Surgery	x	x	x
Treatment for Medical Conditions of the Eye	x	x	x
Health Risk Assessment & Screening Tests (over 21)		x	
HIV/AIDS Antiretroviral Therapy	x	x	x
Home Health Services	x	x	x
Hospice	x		x
Hospital Services			
Inpatient Medical	x	x	x
Observation	x	x	x
Outpatient Medical	x	x	x
Hysterectomy (Medically Necessary)	x	x	x
Immunizations	x	x	x
Laboratory	x	x	x
Maternal & Child Health Services			

Maternity Services	x	x	x
Family Planning	x	x	x
EPSDT (Medical Services)	x		x
Other EPSDT Covered by Title XXI	x		x
Medical Foods	x	x	x
Medical Supplies / Equipment			
DME	x	x	x
Medical Supplies	x	x	x
Prosthetic / Orthotic Devices	x	x	x
Nursing facilities (up to 90 days)	x	x	x
Non Physician First Surgical Assistant	x	x	x
Physician Services	x	x	x
Podiatry	x	x	x
Prescription Drugs	x	x	x
PCP Services	x	x	x
Private Duty Nursing	x	x	x
Radiology and Medical Imaging	x	x	x
Rehabilitation Therapies			
OT - Inpatient	x	x	x
OT - Outpatient	x		x
PT	x	x	x
Speech Therapy – Inpatient	x	x	x
Speech Therapy - Outpatient	x		x
Respiratory Therapy	x	x	x
Total Outpatient Parental Nutrition	x	x	x
Transplantation			
Non-Experimental transplants approved for title XIX reimbursement	x	x	x
Related Immunosupressant drugs	x	x	x
Transportation – Emergency	x	x	x
Transportation – Non Emergency	x	x	x
Triage	x	x	x

Table 3 – AACP Behavioral Management

Behavioral Management	x	x	x
Case Management	x	x	x
Emergency Behavioral Health Care	x	x	x
Evaluation	x	x	x
Therapeutic Residential Support (in home, excluding room and board)	x	x	x
Inpatient Services			
Inpatient Hospital	x	x	x
Inpatient Psychiatric Facilities Consistent with STC paragraph 55.	x	x	x
Lab & X – Ray	x	x	x
Medications (Psychotropic)	x	x	x
Medication Adjustment & Monitoring	x	x	x
Methadone / IAAM	x	x	x
Partial Care	x	x	x
Professional Services			
Individual	x	x	x
Group & Family	x	x	x
Psychosocial Rehabilitation	x	x	x
Respite (with limits)	x	x	x
Screening	x	x	x
Transportation – Emergency	x	x	x
Transportation – Non Emergency	x	x	x

d. **AACP Cost Sharing** – With the exception of individuals eligible for the title XIX waiver group (the MED Expansion Group and adults without dependent children 0-100 percent FPL), cost sharing does not exceed nominal cost sharing limits. Individuals eligible for the title XIX waiver group are subject to the following co-payments:
    i. Generic prescriptions or brand name prescriptions if generic is not available - $4
    ii. Brand name prescriptions when generic is available -$10
    iii. Non-emergency use of the emergency room - $30
    iv. Physician office visit - $5

34. **Children in Foster Care** – Services for Arizona's children in foster care are provided through an MCO contract between AHCCCS and the Arizona DES/CMDP. CMDP operates in the same manner as other AACP Health Plans, but children in foster care who receive acute care services will be enrolled in CMDP instead of other Health Plans. Children in foster care who are eligible for or receive ALTCS will be enrolled or remain with the Program Contractor. Case Management services provided and reimbursed through this contractual relationship must be provided consistent with the provisions within section 6052 of the Deficit Reduction Act of 2005 and any forthcoming regulations.
    a. **Federal Financial Participation**. FFP will not be available for:
        1. Duplicate payments made to public agencies or private entities under other program authorities for case management services or other Medicaid services for the same purpose; or
        2. Activities integral to the administration of the foster care program excluding any health care related activities.

35. **Children Rehabilitative Services (CRS)**. AHCCCS contracts on a sole-source, capitated basis with the Arizona Department of Health Services/Office of Children with Special Health Care Needs/Children's Rehabilitative Services Administration (CRSA) for the CRS program. Children enrolled in the Acute Care and ALTCS plans with qualifying conditions receive their specialty care for these conditions through CRSA while they remain enrolled in their acute care or ALTCS plan.
    a. **CRSA Performance.** AHCCCS and the State's contracted external quality review organization have found ongoing problems with CRSA's performance, including Balanced Budget act of 1997 (BBA) non-compliance and deficiencies in quality-of-care.

    b. **Corrective Action**. The State must submit a Corrective Action Plan to CMS for approval by January 5, 2007, which details the areas of CRSA deficiency, planned corrective action, monitoring timeframes, and outcomes. The State must provide CMS with a quarterly report of the corrective action process as required in paragraph 26 (b).

    In the event that CRSA fails to successfully implement required corrective actions in a timely manner, AHCCCS shall take necessary actions to ensure that CRS-enrolled children are receiving timely access to quality care. Possible actions shall include, but are not limited to,

those described by Federal regulations at 42 CFR 438.702(a)(3)-(5), as determined appropriate by AHCCCS.

36. **Arizona Long Term Care System (ALTCS).** The ALTCS program is for individuals who are aged (65 and over), blind, or disabled and who need ongoing services at a nursing facility level of care. Program eligibles do not have to reside in a nursing home and may live in their own homes or an alternative residential setting and receive needed in-home services. ALTCS participants are also covered for medical care identical to the AACP inclusive of doctor's office visits, hospitalization, prescriptions, lab work, behavioral health services, and rehabilitative services. Rehabilitative services may only be eligible for FFP if these services reduce disability or restore the program enrollee to the best possible level of functionality.

    The ALTCS is administered through a separate, statewide, managed care system which delivers acute, long-term care, home-and-community based services, and behavioral health care services through capitated MCOs that AHCCCS calls "Program Contractors." ALTCS enrollees receive most Medicaid-covered services through the Program Contractors, but receive certain specialty care services for children eligible under the CRS Program on a "carve-out" basis through a separate PIHP contract with the ADHS.

    With one exception, ALTCS contracts are awarded using the same GSA system as the AACP. This exception is for the ALTCS MCO contract with the Arizona DES/DDD to provide services on a statewide basis to all individuals with developmental disabilities. ALTCS enrollees in Maricopa County have a choice of Program Contractors, but ALTCS enrollees in the rest of the State enroll in the Program Contractor for their GSA.

    a. **ALTCS Eligibility Groups -** Individuals as defined in paragraph 32, Table 1 requiring health care services at a nursing facility level of care.
    b. **ALTCS Financial Eligibility** - Individuals must be financially eligible for ALTCS with income equal to or less than 300 percent of the Federal Benefit Rate (FBR), as used by the Social Security Administration to determine eligibility for SSI.
        i. Persons with AHCCCS approved income-only trusts may have income in excess of the FBR.
        ii. The resource (cash, bank accounts, stocks, bonds, etc.) limit is $2,000 for a single individual. Resources, such as a person's home, vehicle, and irrevocable burial plan are not counted toward the resource limit.
        iii. When the applicant has a spouse who resides in the community, the spouse can retain one-half of the couple's resources, up to the Federal maximum as specified in section 1924(f)(2) of the Act. Resources, such as a person's home, vehicle, and irrevocable burial plan are not counted toward the resource limit.
        iv. The total gross income for a married couple is combined and divided by 2. The resulting income may not exceed 300 percent of the single FBR. If the resulting income exceeds 300 percent of the single FBR, the income of the applicant only (name on check) is compared to 300 percent of the single FBR.
    c. **Pre-Admission Screening (PAS) -** Once financial eligibility has been established, a PAS will be conducted by a registered nurse or social worker to determine if the individual is at immediate risk of institutionalization in either a nursing facility or an

ICF/MR. The PAS must be used to determine if the applicant is eligible for ALTCS based on functional, medical, nursing, and social needs of the individual.

d. **ALTCS Benefits and Services**

i. **ALTCS Acute Care** - Enrollees receive the same acute services listed in Table 2 subject to limitations set forth in the existing State plan.

ii. **ALTCS Behavioral Health Care** - Enrollees receive behavioral health care services as outlined in Table 3 for title XIX, subject to limitations set forth in the existing State plan.

iii. **Home and Community-Based Services (HCBS)** ALTCS will provide a comprehensive HCBS package to eligible enrollees in the enrollee's home or in an ALTCS approved Alternative Residential Setting.

1. **Alternative Residential Settings** include:

a. Adult foster care.

b. Assisted living homes, assisted living centers, adult developmental homes, child developmental homes and group homes, hospices, group homes for traumatic brain injured members, and rural substance abuse transitional agencies.

c. Behavioral Health Facilities that are licensed to provide behavioral health services in a structured setting with 24-hour supervision. ALTCS covers services, except room and board, that are provided to ALTCS members who have a behavioral health disorder and are residing in one of the following behavioral health facilities:

i. Level II behavioral health facility – Licensed by ADHS. A HCBS alternative residential behavioral health treatment setting for individuals who do not require the intensity of services or onsite medical services found in a Level I facility.

ii. Level III behavioral health facility - Licensed by ADHS. An HCBS alternative residential behavioral health treatment setting with 24-hour supervision and supportive, protective oversight

These services are excluded for individuals involuntarily living in the secure custody of law enforcement, judicial, or penal systems.

2. **HCBS Services** – Services provided to ALTCS enrollees receiving HCBS are enumerated in Table 4.

Table 4 – ALTCS HCBS

Service	Title XIX	
	EPD	DD
Acute Hospital Admission	X	X
Adult Day Health Services	X	N/A
Attendant Care	X	X
Behavioral Health Services	X	X
DME / Medical Supplies	X	X
Emergency Alert	X	X
Habilitation	X	X

Home Delivered Meals	X	N/A
Home Health Agency Services	X	X
Home Modifications	X	X
Home Maker Services	X	X
Hospice Services (HCBS & Institutional)	X	X
ICF / MR	N/A	X
Medical Care Acute Services	X	X
Nursing Facility Services	X	X
Personal Care	X	X
Respite Care (in home)	X	X
Respite Care (Institutional)	X	X
Therapies	X	X
Transportation	X	X

3. **HCBS Expenditures**- HCBS Expenditures – Expenditures for an individual member are limited to an amount that does not exceed the cost of providing care to the eligible individual in an institutional setting. When determining the cost of providing care to the individual in an institutional setting, the cost of the institutional care will be reduced by an amount calculated under 42 CFR 435.725 regarding the post-eligibility treatment of income of institutionalized individuals. Exceptions are permitted including when the need for additional service is due to a change in condition that is not expected to last more than 6 months.

iv. **Spouses As Paid Care Givers**. AHCCCS may implement a voluntary program for spouses as paid caregivers. The program will provide reimbursement to spouses of eligible ALTCS enrollees, so that the members can remain in their own home for HCBS. Spouses providing care to eligible enrollees will be employed by an ALTCS network contractor, or registered with AHCCCS as an ALTCS independent provider when providing services to an ALTCS FFS Native American or developmentally disabled member. In order for the State to receive FFP from CMS for Paid Caregiver Spouses of Medicaid beneficiaries, the personal care service or support must meet the following criteria and monitoring provisions.

1. Services provided by the Spouse as Paid Caregiver must meet the definition of a "service/support" for personal care or similar services that are rendered by a Paid Caregiver when such services are deemed extraordinary care.
    a. Personal care or similar services – Is defined as assistance with the Activities of Daily Living (ADLs), or Instrumental Activities of Daily Living (IADLs), whether furnished in the home or the community, including personal assistance, attendant care, and closely related services such as home health aide, homemaker, chore, and companion services which may include improving and maintaining mobility and physical functioning, promoting health and personal safety, preparation with meals and snacks, accessing and using transportation, and participating in community experiences and activities.

b. Extraordinary care - Is defined as care that exceeds the range of activities that a spouse would ordinarily perform in the household on behalf of the recipient spouse, if he/she did not have a disability or chronic illness, and which are necessary to assure the health and welfare of the beneficiary, and avoid institutionalization.

2. The Spouse as Paid Caregiver must be a service/support that is specified in a plan of care prepared on behalf of the enrollee.
3. The enrollee who selects the Spouse as Paid Caregiver is not eligible to receive like services from another attendant caregiver.
4. The enrollee will remain eligible to receive other HCBS such as skilled/professional type services, home modifications, respite care, and other services that are not within the scope of the personal/attendant care services prescribed in the provider's plan of care.
5. The Services must be provided by a Spouse as Paid Caregiver who meets specified provider qualifications and training standards prepared by the State for a Paid Caregiver.
6. The Spouse as Paid Caregiver must be paid at a rate that does not exceed that which would otherwise be paid to a provider of a similar service and does not exceed what is allowed by the State Medicaid Agency (SMA) for the payment of personal care/attendant services; and
7. The Spouse as Paid Caregiver will comply with the following conditions.
    a. A Spouse as Paid Caregiver may not be paid for more than 40 hours of services in a 7-day period;
    b. The Spouse as Paid Caregiver must maintain and submit time sheets and other required documentation for hours worked/paid;
    c. The Spouse as Paid Caregiver may only submit claims for services that have been authorized by the Program Contractor or ALTCS FFS case manager;
    d. The ALTCS enrollee must be offered a choice of providers, other than his/her spouse. The enrollee's choice of a Paid Caregiver Spouse as provider must be recorded in his/her plan of care, at least annually.
8. AHCCCS and its Program Contractors must comply with the following monitoring requirements:
    a. Require Program Contractors and FFS case managers to make an on-site case management visit at least every 90 days to reassess a beneficiary's need for services, including the health, safety, and welfare status of the beneficiary serviced by the Spouse as Paid Caregiver;
    b. Require Program Contractors to provide quarterly financial statements that include separate authorized hours and expenditure information for Paid Caregiver Spouses; and

c. Require AHCCCS to perform quarterly financial analysis that includes authorized hours and expenditure information for ALTCS FFS Spouses as Paid Caregivers

v. **Institutional Care** ALTCS will provide institutional care in either a Medicare/Medicaid approved nursing facility, hospice, ICF/MR, inpatient psychiatric hospital, Level I behavioral health residential treatment center, or a Level I behavioral health sub-acute facility if the member requires the level of care in these facilities.

e. **Cost Sharing.**

i. Monthly Premiums for ALTCS. The AHCCCS may implement a monthly premium on ALTCS eligible households with an adjusted gross income at or above 400 percent of the FPL that have children under the age of 18 years with developmental disabilities enrolled in ALTCS.

ii. The total of all monthly premiums will be 2 percent of the annual adjusted gross income for households with income between 400 percent and 500 percent of the FPL and 4 percent for households with income at and above 500 percent the FPL. There will be no distinction between institutional or non-institutional placements.

iii. AHCCCS will compute the premium amount using annual adjusted gross income from the parent's most recent Federal income tax return.

1. Premiums will be billed monthly on the 1st and due on the 15th.
2. AHCCCS will establish a grievance and appeal process allowing families to dispute the initial amount of the premium based on annual income or family size, increases in premiums and discontinuances for failure to pay the monthly premiums or deductibles.
    a. Premiums will continue to be billed and incurred during an eligibility appeal period and failure to pay the premium during the appeal period could mean a loss of eligibility.
    b. If the appeal is based on an increase in the premium amount, the premium increase will not be imposed until after an appeal decision.

f. **Other ALTCS Requirements**

i. The State of Arizona will continue to provide access to ALTCS services to American Indians on the reservation as it does to other citizens of the State.

ii. The State will not deny acute care Medicaid eligibility for any potentially disabled individual based on using PAS criteria in lieu of the SSI-disability determination. Prior to rendering a final decision of ineligibility for acute care services based on disability, the State will use the SSI criteria as required under section 1902(a)(10) as interpreted through Federal regulations at sections 435.120 and 435.601.

iii. In the absence of a limit, AHCCCS will report annually on current placements and ongoing activities for expanding HCB services and settings. The report will be due by March 31 of each year.

iv. The DES/DDD will comply with all contractual and reporting requirements as specified in the contract between AHCCCS and DES/DDD and in any subsequent amendments. DES/DDD will be sanctioned as specified in the

contract if DES/DDD fails to comply with the stated contractual and reporting requirements.

37. **ALTCS Transitional Program**. AHCCCS will complete a second scoring of the PAS for members who are enrolled in ALTCS, but fail to be at "immediate risk of institutionalization" based on the PAS conducted at the time of the re-determination.
    a. If determined eligible for the ALTCS Transitional Program, AHCCCS will transfer the member to the ALTCS Transitional Program which limits institutional services to 90-days per admission and provides the member with medically necessary acute care services, HCBS, behavioral health services and case management services as prescribed in paragraph 36.

38. **Arizona Health Insurance Flexibility and Accountability (HIFA)**
    a. **HIFA Eligible Populations:** The State will use title XXI funds to expand coverage to two populations:
        i. The **Health Insurance Flexibility and Accountability I (HIFA I)** population includes uninsured adults without dependent children over the age of 18 years, with income from 40 percent up to and including 100 percent of the FPL who are not otherwise eligible for Medicare, Medicaid (except for title XIX demonstration expansion groups), SCHIP, or have other creditable health insurance coverage.
        ii. The **Health Insurance Flexibility and Accountability II (HIFA II)** population includes uninsured eligible parents of KidsCare and/or SOBRA eligible children with income from 100 percent up to and including 200 percent of the FPL who are not otherwise eligible for Medicare, Medicaid (including other components of this section 1115 demonstration), SCHIP, or have other creditable health insurance coverage.
    b. **Employer-Sponsored Insurance (ESI):** Arizona must obtain State legislative authority as well as implement and provide services through an ESI program by October 1, 2008.
        i. **Penalty.** Failure to implement the ESI program by October 1, 2008, and to maintain its effective operation throughout the duration of the demonstration period will result in the elimination, beginning July 1, 2007, of title XXI expenditure authority and funds for the HIFA eligible demonstration populations. This does not preclude the State from providing coverage to these demonstration populations using title XIX expenditure authority as specified in this paragraph and paragraph 60. However, the State is not required to meet the 60-day written notification requirements of this paragraph and paragraph 60, and funding may be changed retroactively.
        ii. **CMS Review.** The ESI plan will be subject to CMS approval and must be submitted at least 120 days prior to the planned implementation.
    c. **HIFA Eligibility Processes:**
        i. The eligibility process for uninsured adults without dependent children is identical to the eligibility process currently practiced under title XIX.
        ii. The eligibility process for uninsured parents of Medicaid or SCHIP children is identical to the eligibility process currently practiced under title XXI.
    d. **HIFA Benefits.**

i. Uninsured adults without dependent children receive the adult AACP benefits package.
ii. Uninsured parents receive the adult AACP benefits package.
iii. Enrollees in the ESI program will receive the benefit package available through the employer-sponsored insurance product. Wrap-around services are not provided

e. **HIFA Cost Sharing.**

i. As of October 1, 2006, adults without dependent children follow all AHCCCS cost sharing rules per paragraph 33(d). The State may choose to implement the following co-payments for adults without dependent children:
   1. Generic prescriptions or brand name prescriptions if generic is not available - $4;
   2. Brand name prescriptions when generic is available - $10;
   3. Non-emergency use of emergency room - $30; and
   4. Physician office visit - $5

   The State will notify CMS in writing at least 60 days prior to implementation of these co-payments and include documentation of public notice per paragraph 16.

ii. Parents will have the following fee schedule:

	100%-150% FPL	151%-175% FPL	176%-200% FPL
Premiums (October 1, 2006 through December 31, 2006)	$15/mo - one parent $30/mo – two parents	$20/mo – one parent $40/mo – two parents	$25/mo – one parent $50/mo – two parents
Premiums (effective January 1, 2007)	3% of Net Household Income	4% of Net Household Income	5% of Net Household Income
Enrollment Fee	$15	$20	$25
Deductibles	None	None	None
Co-payments	None	None	None
ER Co-pays	$1 if no emergency	$1 if no emergency	$1 if no emergency

iii. Arizona must submit a revised allotment neutrality budget and documentation of public notice before implementing a change in premiums for parents. The revised budget and public notice documentation must be submitted to CMS 60 days prior to implementation
iv. Enrollees in the ESI program will have cost sharing set by their employer-based coverage.

f. **HIFA Enrollment Data.** Each quarter, the State will provide CMS with end of quarter actual and unduplicated ever-enrolled figures. These enrollment data will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter. The data will also be referenced in the quarterly reports described in paragraph 26. Arizona will report each demonstration population on a separate 21W form in SEDS as long as the State is claiming title XXI for each population. Arizona will use the sub-category "Other adults covered in demonstration" to report adults without dependent children enrollment, and Arizona will use the sub-category "Parents/Caretaker relatives (not Medicaid eligible)" to report parent enrollment. In addition, the State will provide monthly enrollment data as specified by CMS in the monthly Eligibility and Enrollment Reports.

g. **Funding.** The State will establish a monitoring process to ensure that expenditures for the HIFA amendment do not exceed available title XXI funding (i.e., the title XXI allotment or reallocated funds) and the appropriated State match. The State will use title XXI funds to cover services for the SCHIP and HIFA populations in the following priority order:

1) Title XXI State plan eligibles, who are children up to age 19 years with family incomes up to and including 200 percent of the FPL.
2) Uninsured individuals with adjusted net countable family income above 100 percent of the FPL up to and including 200 percent of the FPL who are parents of children enrolled in the Arizona Medicaid or SCHIP programs but who themselves are not eligible for either program.
3) Uninsured adults without dependent children over age 18 years with income above 40 percent of the FPL up to and including 100 percent of the FPL who are also eligible under the Medicaid section 1115 eligibility expansion.
4) If the State determines that title XXI funding will be exhausted, available title XXI funding will first be used to cover costs associated with the title XXI State plan population. The State will not close enrollment, institute waiting lists, or decrease eligibility standards with respect to the children covered under its title XXI State plan while the HIFA amendment is in effect.
5) For the purpose of administering the priority system, no distinction will be made between parents of Medicaid children and parents of SCHIP children. The State may also, for the Medicaid or SCHIP parents and childless adults:
    - Lower the FPL used to determine eligibility, and/or
    - Suspend eligibility determination and/or intake into the program, or
    - Discontinue coverage

    Taking action regarding the FPL will require an amendment to the Demonstration. Action regarding suspension of intake into the program or discontinuation of coverage will require 60-day notice to CMS prior to implementation of the change. If the expansion to parents of Medicaid and SCHIP children is not continued by the State, Arizona will no longer receive title XXI funding for adults without dependent children.
6) For adults without dependent children and parents, title XIX Federal matching funds will be provided if title XXI funding is exhausted. The State must provide CMS with 60 days notification before it begins to draw down title XIX funding for either of these populations. For the parent population, the State must also negotiate budget neutrality before drawing down title XIX matching funds. Once the State has used title XIX funding for parents and/or adults without dependent children, should title XXI funds become available again for these populations, the State must provide CMS with 60 days notification and must submit a revised allotment neutrality budget for CMS approval prior to modifying the Federal funding source.

39. **Family Planning Extension Program.** Family planning services are provided to eligible recipients who lose SOBRA eligibility at 60 days postpartum for up to 24 months with a re-

determination of eligibility, including income, at 12 months. The income limit for re-determination of eligibility is 133 percent of the FPL.

a. **Duplicate Payments.** The State must not use title XIX funds to pay for individuals enrolled in regular Medicare, Medicaid, SCHIP, any other federally-funded program (i.e., title X), or component of this section 1115 demonstration who seek services under the family planning extension program. Effective October 1, 2007, the State shall only enroll or reenroll individuals into the family planning demonstration that are uninsured (defined as not having creditable coverage). The State will have up to 1 year from the date of the approval letter to begin disenrolling insured individuals at their annual eligibility redetermination. During this 1 year period, the State shall pursue third party liability reimbursement for any individual who has other insurance and ensure that Medicaid will be the payer of last resort.

b. **Primary Care Referral.** The State shall facilitate access to primary care services for enrollees in the family planning extension program. The State shall submit to CMS a copy of the written materials that are distributed to the family planning extension program participants as soon as they are available. The written materials must explain to the participants how they can access primary care services. In addition, the State must evaluate the impact of providing referrals for primary care services. This component of the evaluation must be highlighted in the evaluation design that will be submitted to CMS as specified in paragraph 42(b) of this document.

c. **Eligibility Re-determinations.** The State will ensure that re-determinations of eligibility for this component of the Demonstration are conducted, at a minimum, once every 12 months in accordance with Federal regulations at 42 CFR 435.916. The State shall submit for CMS approval its process for eligibility re-determinations within 30 days of the date of the Demonstration award letter. The process for eligibility re-determinations shall not be passive in nature, but will require that an action be taken by the family planning expansion program recipient in order to continue eligibility for this program. The State may satisfy this requirement by having the recipient sign and return a renewal form to verify the current accuracy of the information previously reported to the State.

d. **Reporting Requirements Related to Family Planning Extension.**

    i. In each annual report described in paragraph 27, the State shall report the average total Medicaid expenditures for a Medicaid-funded birth each year. The cost of a birth includes prenatal services and delivery and pregnancy-related services and services to infants from birth through age 1-year. (The services should be limited to the services that are available to women who are eligible for Medicaid because of their pregnancy and their infants.)

    ii. In each annual report described in paragraph 27, the State shall report the number of actual births that occur to family planning extension demonstration participants (Participants include all individuals who obtain one or more covered medical family planning services through the family planning extension program) each year.

    iii. The State will submit to CMS base-year fertility rates and a methodology for calculating the fertility rates no later than March 31, 2007. For purposes of this section, “fertility rate” means birth rate. These rates must:

        1. Reflect fertility rates during Base Year 2003 for women, age 19-44 years, with family incomes between 100 percent to 133 percent of the

FPL and ineligible for Medicaid except for pregnancy.

2. Be adjusted for age, using age bands, for all potential Demonstration participants.
3. Include births paid for by Medicaid.
4. At the end of each demonstration year (DY), a DY fertility rate will be determined by summing the age-specific rates using the age distribution of the Demonstration participants during that DY to weight the age-specific fertility rates, unless the State demonstrates that the age distribution is consistent with the prior DY(s). The annual age distribution categories will correspond with the base-year age-specific fertility rates. The intent of the Demonstration is to avert unintended pregnancies to offset the cost of family planning services for Demonstration participants. The base-year fertility rate and the DY fertility rate will be used to calculate a measure of births averted through the demonstration using the following formula: 'Births Averted' = the [(base year fertility rate) minus (fertility rate of demonstration participants during DY)] multiplied by the (number of demonstration participants during DY).

iv. No later than 30 days after the waiver approval letter, the State will provide to CMS for approval an appropriate methodology for ensuring the integrity of annual eligibility determinations of individuals covered under the family planning extension program. The State will use this methodology to conduct reviews of the eligibility determination process on an annual basis. As part of the submission, the State will also develop an eligibility determination error rate methodology. If annual reviews of the eligibility determination process suggest error rates beyond a State established threshold, the State will develop a corrective action plan for CMS approval.

e. **Extent of Federal Financial Participation for Family Planning Extension Program.** CMS shall provide FFP for CMS-approved services (including prescriptions) provided to women under the family planning extension program at the following rates and as described in Attachment C:

i. For procedures or services clearly provided or performed for the primary purpose of family planning (contraceptives and sterilizations) and which are provided in a family planning setting, FFP will be available at the 90-percent Federal matching rate. Procedure codes for office visits, laboratory tests, and certain other procedures must carry a diagnosis that specifically identifies them as a family planning service.

ii. FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for sexually transmitted infections as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. Subsequent treatment would be paid for at the applicable Federal matching rate for Arizona. For testing or treatment not associated with a family planning visit, no FFP will be available.

iii. CMS will provide FFP at the appropriate 90 percent administrative match rate for administration of the offering, arranging, and furnishing of family

planning services. General administration costs of the program, including, for example, outreach costs, claims processing, program development, and monitoring will receive the appropriate 50 percent administrative match rate.

iv. Arizona will provide to CMS an updated list of Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding Systems (HCPCS) codes covered under the Demonstration on January 31 of each DY. The revised code list should reflect only changes due to updates in the services and should only include services for which the State has already received approval.

v. Changes to Attachment C will require an amendment to the Demonstration.

VI. DELIVERY SYSTEMS

40. **Contracts.** All contracts and modifications of existing contracts between the State and MCOs must be prior-approved by CMS. The State will provide CMS with a minimum of 30 days to review and approve changes.

41. **Health Services to Native American Populations.** The plan currently in place for patient management and coordination of services for Medicaid-eligible Native Americans, developed in consultation with the Indian tribes and/or representatives from the Indian health programs located within the State, shall continue in force for this extension period.

VII. EVALUATION

42. **State Must Separately Evaluate Components of the Demonstration.** As outlined in subparagraphs (a), (b), and (c), the outcomes from each evaluation component must be integrated into one programmatic summary that describes whether the State met the Demonstration goal, with recommendations for future efforts regarding all components. The State must submit to CMS for approval a draft evaluation design no later than February 1, 2007. The evaluation must outline and address evaluation questions for all of the following components:

a) The State must submit to CMS for approval a draft evaluation design no later than 6-months after the demonstration award. At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target populations within the Acute Care, ALTCS, and HIFA/ESI programs within the demonstration. The draft design shall discuss the outcome measures that must be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes (Attachment B – Evaluation Design Guidelines). The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration are isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

b) **Family Planning Extension Program**. The draft design must include a discussion of the goals, objectives, and evaluation questions specific to this component of the

Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the family planning extension program, particularly among the target family planning population, during the period of approval. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the family planning extension program shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation. The report should also include an integrated presentation and discussion of the specific evaluation questions (including those that focus specifically on the target population for the family planning program) that are being tested. At a minimum, the following data elements will be included in the measurement methodology:

Measure	Number	Percentage Change
Enrollment		
Averted Births		
Family Planning Patients Receiving a Clinical Referral for Primary Care	(estimate can be based on a sample)	

c) **HIFA Evaluation**. Arizona must conduct an evaluation of the HIFA demonstration as described in paragraph 43. The State shall report on its progress in the quarterly and annual reports. AHCCCS will monitor and report on progress toward agreed-upon goals for reducing the rate of uninsurance. AHCCCS will also monitor the private insurance market as it relates to the ESI program (e.g., changes in employer contribution levels, trends in sources of insurance, etc.). AHCCCS will also continue to monitor substitution of coverage (i.e., participants dropping private coverage to enroll in the Demonstration). Finally, AHCCCS will study the goals, objectives, and hypotheses that have been proposed as part of this HIFA demonstration with a specific focus on the link between parental and adult coverage under this Demonstration and health care coverage for children.

43. **Final Evaluation Design and Implementation.** CMS must provide comments on the draft design, within 60 days of receipt, and the State must submit a final design within 60-days of receipt of CMS comments. The State must implement the evaluation design, and submit to CMS a draft of the evaluation 120 days after the expiration of the demonstration. CMS shall provide comments within 60 days of receipt of the draft evaluation. Within 60 days of receipt of comments from CMS, a revised final report must be submitted.

44. **Cooperation with Federal Evaluators.** Should CMS undertake an evaluation of the Demonstration, the State must fully cooperate with Federal evaluators' and their contractors' efforts to conduct an independent, federally funded evaluation of the Demonstration program.

VIII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

45. **Quarterly Expenditure Reports.** Effective with the quarter beginning October 1, 2006, the State shall provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in this Agreement.

46. **Reporting Expenditures in the Demonstration**. The following describes the reporting of expenditures subject to the budget neutrality cap:

    a) **Tracking Expenditures.** In order to track expenditures under this Demonstration, Arizona shall report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap shall be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or 10.C. For any other cost settlements (i.e., those not attributable to this Demonstration), the adjustments should be reported on lines 9 or 10.C, as instructed in the State Medicaid Manual. The term, "expenditures subject to the budget neutrality cap," is defined below.

    b) **Use of Forms**. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the Demonstration, subject to the budget neutrality cap. The State must complete separate forms for the following categories:
        i. AFDC/SOBRA
        ii. SSI
        iii. AC/MED
        iv. ALTCS-DD
        v. ALTCS-EPD
        vi. Family Planning Extension
        vii. HIFA II (Parents)*
        viii. DSH and CAHP (Critical Access Hospital Payments)

        * Reporting Expenditures in the Demonstration for individuals in these categories must be in accordance with paragraph 60.

    c) **Family Planning Extension**. For the family planning extension component (defined as the AHCCCS-eligible women who lose SOBRA eligibility at 60 days postpartum and receive family planning services for up to 24 months) of the Demonstration, the State should report Demonstration expenditures on Forms CMS-64.9 Waiver and/or

64.9P Waiver as follows:

i. Allowable family planning expenditures eligible for reimbursement at the State's Federal medical assistance percentage rate (FMAP) should be entered in Column (B) on the appropriate waiver sheets.

ii. Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets.

d) **Expenditures Subject to the Budget Neutrality Cap**. For purposes of section VIII, the term "expenditures subject to the budget neutrality cap" shall include all Medicaid expenditures except those as described below, on behalf of the individuals who are enrolled in this Demonstration. Expenditures excluded from this Demonstration and the budget neutrality cap are the Medicaid in the Public Schools- Direct Services Claiming program expenditures, Breast and Cervical Cancer Treatment program expenditures, Freedom to Work program expenditures, and all administrative expenditures.

e) **Premium and Cost Sharing Adjustment**. Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration shall be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that the Demonstration is properly credited with premium collections, premium collections (both total computable and Federal share) should also be reported on the CMS-64 Narrative. The State should include these section 1115 premium collections as a manual adjustment (decrease) to the Demonstration's actual expenditures on a quarterly basis.

f) **Administrative Costs.** Administrative costs shall not be included in the budget neutrality limit. All administrative costs shall be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

g) **Claiming Period**. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

47. **Reporting of Member Months.** The following describes the reporting of member months subject to the budget neutrality cap:

a) For the purpose of calculating the budget neutrality expenditure cap described in this Agreement, the State shall provide to CMS on a quarterly basis the actual number of eligible member months for all Eligibility Groups. This information shall be provided to CMS 30 days after the end of each quarter as part of the CMS-64

submission, either under the narrative section of the MBES/CBES or as a stand-alone report.

b) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member months.

c) For the purposes of this Demonstration, the term “Demonstration eligibles” refers to all individuals covered by Arizona Medicaid with the exception of individuals in the Freedom to Work and Breast and Cervical Cancer Treatment programs.

48. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure cap and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

49. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in this Agreement.
    a) Administrative costs, including those associated with the administration of the Demonstration;
    b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan;
    c) Net expenditures and prior period adjustments made with dates of service during the operation of the Demonstration.

50. **Medicare Part D Drugs.** No FFP is available for this Demonstration for Medicare Part D drugs.

51. **Sources of Non-Federal Share.** The State certifies that the non-Federal share of funds for the Demonstration is State/local monies. The State further certifies that such funds shall not be used to match any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.
    a) CMS shall review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed

unacceptable by CMS shall be addressed within the time frames set by CMS.

b) Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

c) Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

52. **Certification of Public Expenditures.** The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.

b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

(1) To the extent that Arizona currently claims Federal matching dollars using CPEs as the funding mechanism, the State may continue to use a payment methodology and cost documentation process in place prior to October 1, 2006. All other requirements of this term and condition are still applicable and the State is subject to any policy guidance or regulation released by CMS regarding the use of CPEs. Any changes made to these methodologies through the Medicaid State plan are subject to review and are bound to all applicable rules governing sources of non-Federal share.

(2) To the extent that Arizona institutes the use of CPEs after October 1, 2006, the requirements of this term and condition fully apply. The State is subject to any policy guidance or regulation released by CMS regarding the use of CPEs.

(3) The State must submit a disproportionate share hospital (DSH) payment methodology for the Arizona State Hospital (ASH) and the Maricopa Medical Center prior to June 30, 2007. This payment methodology will be cost reimbursement and will utilize CPEs as the funding system. The methodology and the cost identification/reconciliation process must be approved by CMS prior to the State claiming federal match for DSH payments effective July 1, 2007. This DSH payment methodology will be an amendment to the DSH methodology in Attachment D.

c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration to non-governmental providers, the governmental entity appropriating funds to the provider must certify to the State the amount of such tax revenue (State or local) appropriated to the non-governmental provider used to satisfy demonstration expenditures. The non-governmental provider

that incurred the cost must also provide cost documentation to support the State's claim for Federal match.

d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

53. **Applicability of Fee for Service Upper Payment Limits.** If expenditures (excluding expenditures for members enrolled with the Indian Health Service for inpatient hospital and long-term care facility services, other institutional and non-institutional services (including drugs) provided to AHCCCS fee-for-service beneficiaries equal or exceed 5 percent of the State's total Medical Assistance expenditures, the expenditure authority will be terminated and the State shall submit a demonstration amendment that includes a plan to comply with the administrative requirements of section 1902(a)(30)(A). The State shall submit documentation to CMS on an annual basis that shows the percentage AHCCCS fee-for-service beneficiary expenditures as compared to total Medical Assistance expenditures.

54. **Proper and Efficient Administration of the Plan.** Upper Payment Limits allow the State to enhance Medicaid payments to health care providers as long as the payments do not exceed what Medicare payment principles would have paid for the same service. By March 31, 2007, the State must submit to CMS a report that provides justification for any areas in which the State's rate setting methodology may not be in compliance with section 1902(a)(30)(A). The report will describe any changes to the fee-for-service rate setting methodology the State plans to implement.

55. **Institutions for Mental Disease (IMD) Phase Down –** Allowable expenditures that will be recognized for purposes of this demonstration will be phased down for services to Arizona enrollees ages 21 through 64 years of age residing in IMDs for the first 30 days of an inpatient episode, subject to an aggregate annual limit of 60 days. Allowable expenditures will be recognized in accordance with the chart below.

Period	Allowable Portion of Expenditures
October 1, 2006-September 30, 2007	100%
October 1, 2007-September 30, 2008	50%
October 1, 2008-September 30, 2009	0%

56. **Fraud and Abuse Recoveries**: Medicaid is the largest source of funding for medical and health-related services for people with limited income. States are primarily responsible for policing fraud in the Medicaid program and CMS provides technical assistance, guidance, and oversight in these efforts. CMS is requiring:
    a) The State to develop and submit for review an action plan by April 1, 2007, to enhance Medicaid fraud and abuse recoveries by the end of the Demonstration extension period ending September 30, 2011.
    b) The State must provide CMS with an annual report of the State's action plan as required in paragraph 27.
    c) The State to demonstrate by September 30, 2010, that their level of recoveries is equal to or greater than the level approved by CMS.

IX. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

57. **Quarterly SCHIP Expenditure Reports.** The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided to all Demonstration populations receiving title XXI funds under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS will provide FFP only for allowable Demonstration title XXI expenditures that do not exceed the State's available title XXI funding.

58. **Tracking SCHIP Expenditures.** In order to track title XXI expenditures under this Demonstration, the State will report Demonstration expenditures through the MBES/CBES, following routine CMS-21 reporting instructions as outlined in section 2115 of the State Medicaid Manual. Title XXI Demonstration expenditures will be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver (i.e., HIFA1 and HIFA Parents), identified by the Demonstration project number assigned by CMS (including project number extension, which indicates the DY in which services were rendered or for which capitation payments were made).
    a) **SCHIP Claiming.** All claims for expenditures related to the Demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2 year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the Form CMS-21.
    b) **Standard SCHIP Funding Process.** The standard SCHIP funding process will be used during the Demonstration. Arizona must estimate matchable SCHIP expenditures on the quarterly Form CMS-21B. On a separate CMS-21B, the State shall provide updated estimates of expenditures for the Demonstration population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly SCHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.
    c) **Sources of SCHIP Non-Federal Share.** The State will certify State/local monies used as matching funds for the Demonstration and will further certify that such funds will

not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law. All sources of non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the timeframes set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding

59. **Limit on Title XXI Funding**. Arizona will be subject to a limit on the amount of Federal title XXI funding that the State may receive for Demonstration expenditures during the Demonstration period. Federal title XXI funding available for Demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the Demonstration until the next allotment becomes available. In addition, failure to implement and maintain the ESI program as described in paragraph 38(b) will result in the State repaying the difference between title XXI FFP and title XIX FFP so that the State receives the lower FFP rate for the adult HIFA populations beginning July 1, 2007, through the end of the renewal period.

60. **Drawdown of Title XIX Funds.**

    a) **HIFA Adults without Dependent Children**. For Adults without Dependent Children, title XIX Federal matching funds will be provided if title XXI funding is exhausted. As of October 1, 2006, Arizona is claiming title XIX matching funds and is including such funds in its Budget Neutrality calculations. The State must provide CMS with 60-days notification before it begins to draw down title XIX matching funds for this demonstration population. Once the State has used title XIX funding for this population, should title XXI funds become available again for this population, the State must provide CMS with 60 days written notification and must submit a revised allotment neutrality budget for CMS approval prior to modifying the Federal funding source.

    b) **HIFA Parents**. For Parents, title XIX Federal matching funds will be provided if title XXI funding is exhausted. The State must provide CMS with 60 days notification before it begins to draw down title XIX matching funds for this demonstration population. The State must also negotiate budget neutrality before drawing down title XIX matching funds for this demonstration population in accordance with section X – "Monitoring Budget Neutrality." Once the State has used title XIX funding for this population, should title XXI funds become available again for this population, the State must provide CMS with 60 days written notification and must submit a revised allotment neutrality budget for CMS approval prior to modifying the Federal funding source.

61. **Compliance with Federal Rules.** All Federal rules shall continue to apply during the period of the Demonstration if title XXI Federal funds are not available and the State decides to continue the program.

X. MONITORING BUDGET NEUTRALITY

62. **Monitoring Demonstration Funding Flows.** The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.
    a) Each year, AHCCCS will monitor and ensure that for each contract year, the DES/DDD and the ADHS/BHS have provided the appropriate State match necessary to draw down the FMAP for title XIX services provided, respectively, to ALTCS eligible persons and to AHCCCS eligible persons enrolled with ADHS/BHS. Specifically, AHCCCS and DES/DDD entered into an Intergovernmental Agreement, effective July 1, 1998, whereby DES/DDD transfers to AHCCCS the total amount appropriated for the State match for title XIX ALTCS expenditures. Likewise, AHCCCS and ADHS/BHS entered into an Intergovernmental Agreement, effective July 1, 1999, whereby ADHS/BHS transfers to AHCCCS the total amount appropriated for the State match for title XIX expenditures. AHCCCS deposits the monies transferred into an Intergovernmental Fund from which AHCCCS has sole disbursement authority.

    b) AHCCCS will report on a comparison of revenues and costs associated with the DES Interagency Agreement, including how any excess revenues are spent. AHCCCS will also report this information for ADHS/BHS. Both reports will be due by January 15 of each year for the State fiscal year ending the previous June 30.

63. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method, and budget neutrality expenditure caps are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. The data supplied by the State to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

64. **Risk.** The State shall be at risk for the per capita cost (as determined by the method described below) for Demonstration eligibles under this budget neutrality agreement, but not for the number of Demonstration eligibles in each of the groups. By providing FFP for all Demonstration eligibles, the State shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing the State at risk for the per capita costs for Demonstration eligibles under this agreement, CMS assures that Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

65. **Demonstration Populations and Programs Subject to the Budget Neutrality Agreement.** The following Demonstration populations are subject to the budget neutrality agreement and are incorporated into the following eligibility groups (EGs):

    a) Eligibility Group 1: AFDC / SOBRA
    b) Eligibility Group 2: SSI
    c) Eligibility Group 3: ALTCS-DD
    d) Eligibility Group 4: ALTCS–EPD
    e) Program Group 1: DSH

66. **Budget Neutrality Expenditure Cap:** The following describes the method for calculating the budget neutrality expenditure cap for the Demonstration:

a) For each year of the budget neutrality agreement an annual budget neutrality expenditure cap is calculated for each eligibility group described in paragraph 65 as follows:
   i) An annual eligibility group expenditure cap must be calculated as a product of the number of eligible member months reported by the State under paragraph 47 for each eligibility group, times the appropriate estimated per member per month (PM/PM) costs from the table in subparagraph (iii) below.
   ii) The PM/PM costs in subparagraph (iii) below are net of premiums paid by Demonstration eligibles.
   iii) The PM/PM costs for the calculation of the annual budget neutrality expenditure cap for the eligibility groups subject to the budget neutrality agreement under this Demonstration are specified below. In addition, the PM/PM cost for each eligibility group in DY 6 has been increased by the appropriate growth rate included in the President's Federal fiscal year 2007 budget for DYs 7, 8, 9, and 10, as outlined below.

Eligibility Group	Trend Rate	DY 6	DY 7	DY 8	DY 9	DY 10
AFDC / SOBRA	7.2%	$421.27	$451.60	$484.12	$518.98	$556.35
SSI	7.2%	$632.50	$678.04	$726.86	$779.19	$835.29
ALTCS - EPD	7.2%	$3409.91	$3655.42	$3918.61	$4200.75	$4503.20
ALTCS - DD	7.2%	$3516.33	$3769.51	$4040.91	$4331.86	$4643.75

   iv. The annual budget neutrality expenditure cap for the Demonstration as a whole is the sum of DSH allotment plus the annual expenditure caps for each eligibility group calculated in subparagraph 66(a)(i) above.

b) The overall budget neutrality expenditure cap for the 5-year demonstration period is the sum of the annual budget neutrality expenditure caps calculated in subparagraph 66(a)(iv) above for each of the 5 years. The Federal share of the overall budget neutrality expenditure cap represents the maximum amount of FFP that the State may receive for expenditures on behalf of Demonstration populations and expenditures described in paragraph 46 during the Demonstration period.
c) Apply the effective FMAP that is determined from the MBES/CBES Schedule C report.

67. **Enforcement of Budget Neutrality.** CMS shall enforce budget neutrality over the life of the Demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative budget neutrality expenditure cap by the percentage identified below for any of the DYs, the State must submit a corrective action plan to CMS for approval.

Cumulative Demonstration Years	Cumulative Expenditure Cap Definition	Percentage
Years 1 through 6	Budget neutrality expenditure cap plus	1.0 %
Years 1 through 7	Combined budget neutrality expenditure caps plus	0.75 %
Years 1 through 8	Combined budget neutrality expenditure caps plus	0.5 %
Years 1 through 9	Combined budget neutrality expenditure caps plus	0.25 %
Years 1 through 10	Combined budget neutrality expenditure caps plus	0.0 %

68. **Exceeding Budget Neutrality.** If, at the end of this Demonstration period the overall budget neutrality expenditure cap has been exceeded, the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

XI. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date	Deliverable
November 27, 2006	State Acceptance Letter of Demonstration Extension, STCs, Waivers, and Expenditure Authorities
November 27, 2006	The State will provide to CMS for approval an appropriate methodology for ensuring the integrity of annual eligibility determinations of individuals covered under the family planning extension program. STC #39 (c).
January 5, 2007	The State will provide to CMS for approval a corrective action plan for ensuring the integrity of the Children's Rehabilitative Service program. STC #35 (b).
February 1, 2007	Submission of draft Evaluation Design that includes the HIFA and Family Planning Extension Program Evaluation Designs STC # 42
March 31, 2007	Submission of Base Year Fertility Rate – STC# 39(d)(iii)
March 31, 2007	Submission of UPL Report – STC# 54
June 1, 2007	Submission of ESI plan – STC#(38)(b)
September 30, 2010	Written Notice of State's Intent to Extend the Demonstration Under 1115
March 31, 2011	Complete Demonstration Extension Application (1115)
January 31, 2012	Submission of final Evaluation Design STC # 43
May 30, 2012	Submit Draft Evaluation Report- STC # 42
September 30, 2012	Final Evaluation Report due-clause 43. Final Report- STC# 28. End of Demonstration Period.
Monthly Deliverables	Monthly call- STC# 25
	HIFA Enrollment Data by demonstration group - STC# 38(f)
	Family Planning Enrollment Data
Quarterly Deliverables	Requirements for Quarterly Reports- STC# 26,
	Quarterly Budget Neutrality Reports- STC# 21
	Expenditure Reports CMS 64 and CMS21- STC# 45 and STC# 57
	Member Months Report- STC# 46
	SEDS Enrollment Data - STC# 38(f)
Annual Deliverables	Requirement for Annual Report- STC# 27,
	Requirement for annual HCBS Report on March 31st- STC# 35 (f)(iv)
	Comparison of Costs for the DES Interagency Agreement, including how any excess revenues are spent, and for ADHS/BHS. Both reports will be due by January 15 – STC # 62 (b)
	Annual Fertility Rates – October 31 STC # 39(d)(iii)(4)

Attachment A - Quarterly Report Guidelines

As written in STC paragraph 26, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 30 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include the budget neutrality monitoring workbook. An electronic copy of the report narrative and the Microsoft Excel budget neutrality monitoring workbook is provided.

NARRATIVE REPORT FORMAT:

TITLE

Title Line One – Arizona Health Care Cost Containment System -- AHCCCS, A Statewide Approach of Cost Effective Health Care Financing

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 5 (5/01/04 - 4/30/05)
Federal Fiscal Quarter: 4/2004 (7/04 - 9/04)

INTRODUCTION:

Information describing the goal of the Demonstration, what it does, and key dates of approval /operation. (This should be the same for each report.)

ENROLLMENT INFORMATION:

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by "0".

Note: Enrollment counts should be person counts, not participant months.

Population Groups (as hard coded in the CMS 64)	**Current Enrollees** (to date)	**No. Voluntary Disenrolled in current Quarter**	**No. Involuntary Disenrolled in current Quarter**
Population 1 – AFDC / SOBRA			
Population 2 - SSI			
Population 3 – ALTCS DD			
Etcetera			

Voluntary Disenrollments:
Cumulative Number of Voluntary Disenrollments Within Current Demonstration Year:
Reasons for Voluntary Disenrollments:

Involuntary Disenrollments:
Cumulative Number of Involuntary Disenrollments Within Current Demonstration Year:
Reasons for Involuntary Disenrollments:

Outreach/Innovative Activities:

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues:

Identify all significant program developments/issues/problems that have occurred in the current quarter.

Financial/Budget Neutrality Developments/Issues:

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the State's actions to address these issues.

Consumer Issues:

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity:

Identify any quality assurance/monitoring activity in current quarter.

HIFA Issues:
Identify all significant program developments/issues/problems that have occurred in the current quarter. Include an analysis of current title XXI allotment availability, and include enrollment data, point-in-time and ever-enrolled, by HIFA coverage groups

ESI Issues:
Identify all significant program developments/issues/problems that have occurred in the current quarter.

Family Planning Extension Program:
Identify all significant program developments/issues/problems that have occurred in the current quarter. Include enrollment data.

Enclosures/Attachments:

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s):

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

The State may also add additional program headings as applicable.

Date Submitted to CMS:

Attachment B – Evaluation Guidelines

Section 1115 demonstrations are valued for information on health services, health services delivery, health care delivery for uninsured populations, and other innovations that would not otherwise be part of Medicaid programs. The CMS encourages States with demonstration programs to conduct or arrange for evaluations of the design, implementation, and/or outcomes of their demonstrations. The CMS also conducts evaluation activities.

The CMS believes that all parties to demonstrations; States, Federal Government, and individuals benefit from State conducted self-evaluations that include process and case-study evaluations – these would include, but not be limited to: 1) studies that document the design, development, implementation, and operational features of the demonstration, and 2) studies that document participant and applicant experiences that are gathered through surveys, quality assurance activities, grievances and appeals, and in-depth investigations of groups of participants and applicants and/or providers (focus groups, interviews, other). These are generally studies of short-term experiences and they provide value for quality assurance and quality improvements programs (QA/QI) that are part of quality assurance activities and/or demonstration refinements and enhancements.

Benefit also derives from studies of intermediate and longer-term investigations of the impact of the demonstration on health outcomes, self-assessments of health status, and/or quality of life. Studies such as these contribute to State and Federal formation and refinements of policies, statutes and regulations.

States are encouraged to conduct short-term studies that are useful for QA/QI that contribute to operating quality demonstration programs. Should States have resources available after conducting these studies, they are encouraged to conduct outcome studies.

The following are criteria and content areas to be considered for inclusion in Evaluation Design Reports.

- Evaluation Plan Development - Describe how plan was or will be developed and maintained:
    - Use of experts through technical contracts or advisory bodies;
    - Use of techniques for determining interest and concerns of stakeholders (funding entities, administrators, providers, clients);
    - Selection of existing indicators or development of innovative indicators;
    - Types of studies to be included, such as Process Evaluations, Case-Studies and Outcome investigations;
    - Types of data collection and tools that will be used – for instance, participant and provider surveys and focus groups; collection of health service utilization; employment data; or, participant purchases of other sources of health care coverage; and whether the data collection instruments will be existing or newly developed tools;
    - Incorporation of results through QA/QI activities into improving health service delivery; and

- Plans for implementation and consideration of ongoing refinement to the evaluation plan.

- Study Questions – Discuss:
  - Hypothesis or research questions to be investigated;
  - Goals, such as:
    - Increase Access
    - Cost Effectiveness
    - Improve Care Coordination
    - Increase Family Satisfaction and Stability
  - Outcome Measures, Indicators, and Data Sources

- Control Group and/or Sample Selection Discussion:
  - The type of research design(s) to be included -
    - Pre/Post Methodology
    - Quasi-Experimental
    - Experimental
  - Plans for Base-line Measures and Documentation – time period, outcome measures, indicators, and data sources that were used or will be used

- Data Collection Methods – Discuss the use of data sources such as:
  - Enrollment and outreach records;
  - Medicaid claims data;
  - Vital statistics data;
  - Provide record reviews;
  - School record reviews; and
  - Existing or custom surveys

- Relationship of Evaluation to Quality Assessment and Quality Improvement Activities– Discuss:
  - How evaluation activities and findings are shared with program designers, administrators, providers, outreach workers, etc., in order to refine or redesign operations;
  - How findings will be incorporated into outreach, enrollment and education activities;
  - How findings will be incorporated into provider relations such as provider standards, retention, recruitment, and education; and
  - How findings will be incorporated into grievance and appeal proceedings.

- Discuss additional points as merited by interest of the State and/or relevance to nuances of the demonstration intervention.

Attachment C – Family Planning Procedure Codes

The services listed in this attachment do not guarantee coverage by the State. The inclusion of services is solely for the purposes of indicating the codes for which Federal financial participation is available under this Family Planning Extension Program.

CODE	DESCRIPTION	90% FFP	90% FFP with V25 or FP
00851	ANES;TUBAL LIGATION/TRANSECTION	X	
11975	INSERTION, IMPLANTABLE CONTRACEPTIVE CAPSULES	X	
11976	REMOVAL WITHOUT REINSERTION, IMPLANT	X	
11977	REMOVAL WITH REINSERTION IMPLANTABLE CONTRACEPTIVE CAPSULES	X	
36415	COLLECT VENOUS BLOOD BY VENIPUNCTURE		X
57170	DIAPHRAGM FITTING.WITH INSTRUCTIONS	X	
58300	INSERT INTRAUTERINE DEVICE	X	
58301	REMOVE INTRAUTERINE DEVICE	X	
58600	DIVISION OF FALLOPIAN TUBES	X	
58615	OCCLUSION OF FALLOPIAN TUBE, DEVICE	X	
58670	LAPAROSCOPY, TUBAL CAUTERY	X	
58671	LAPAROSCOPY, TUBAL BLOCK	X	
62311	INJECTIONS; LUMBAR, SACRAL		X
62319	INJECT SPINE W/CATH L/S (EPIDURAL OR CAUDAL)		X
80048	BASIC METABOLIC PANEL		X
80050	GENERAL HEALTH SCREEN PANEL		X
80051	ELECTROLYTE PANEL		X
80061	LIPID PROFILE		X
81000	URINALYSIS WITH MICROSCOPY		X
81001	URINALYSIS, AUTO, W/SCOPE		X
81002	ROUTINE URINE ANALYSIS		X
81003	URINALYSIS, BY DIP STICK OR TABLET R		X
81005	URINALYSIS		X
81025	URINE PREG TEST-BY VISUAL COLOR COMP		X
82948	STICK ASSAY OF BLOOD GLUCOSE		X
82962	GLUCOSE, BLOOD, BY GLUCOSE MONITORIN		X
83020	ASSAY HEMOGLOBIN		X
83021	ASSAY HEMOGLOBIN CHROMATOGRAPHY		X
84520	ASSAY BUN		X
84550	ASSAY BLOOD URIC ACID		X
84702	GONADOTROPIN,CHORIONIC; QUANTITATIVE		X
84703	GONADOTROPIN,CHORIONIC;QUALITATIVE		X
85013	SPUN HEMATOCRIT		X
85014	BLOOD COUNT OTHER THAN SPUN HEMATOCRIT		X
85018	BLOOD COUNT: HGB		X
86592	SYPHILIS TEST(S),QUALITATIVE		X
86593	SYPHILIS TEST, QUANTITATIVE		X
86631	ANTIBODY;CHLAMYDIA		X
86645	ANTIBODY;CYTOMEGALOVIRUS		X
86687	ANTIBODY; HTLV-I		X
86688	ANTIBODY; HTLV-II		X

86689	CONFIRMATORY TEST HYLV or HIV		X
86701	ANTIBODY; HIV-1		X
86702	ANTIBODY; HIV2		X
86703	ANTIBODY; HIV 1 AND 2 SINGLE ASSAY		X
87070	CULTURE SPECIMEN, BACTERIA		X
87075	CULTURE SPECIMEN, BACTERIA		X
87081	BACTERIA CULTURE SCREEN		X
87110	CULTURE, CHLAMYDIA, ANY SOURCE		X
87210	SMEAR, STAIN & INTERPRET		X
87270	CHYLMD TRACH AG, DFA		X
87320	CHYLMD TRACH AG, EIA		X
87390	HIV-1 AG, EIA		X
87391	HIV-2 AG, EIA		X
87480	CANDIDA, DNA, DIR PROBE		X
87481	CANDIDA, DNA, AMP PROBE		X
87490	CHYLMD TRACH, DNA, DIR PROBE		X
87491	CHYLMD TRACH, DNA, AMP PROBE		X
87528	HERPES SIMPLEX VIRUS, DIRECT PROBE TECHNIQUE		X
87529	HERPES SIMPLEX VIRUS, AMPLIFIED PROBE TECHNIQUE		X
87590	N.GONORRHOEAE, DNA, DIR PROB		X
87591	N.GONORRHOEAE, DNA, AMP PROB		X
87620	HPV, DNA, DIR PROBE		X
87621	HPV, DNA, AMP PROBE		X
87810	CHYLMD TRACH ASSAY W/OPTIC		X
87850	N. GONORRHOEAE ASSAY W/OPTIC		X
88108	CYTOPATHOLOGY,FLUIDS,WASHINGS		X
88141	CYTOPATH CERV/VAG INTERPRET		X
88142	CYTOPATH CERV/VAG THIN LAYER		X
88143	CYTPATH C/VAG T/LAYER REDO		X
88147	CYTPATH C/VAG AUTOMATED		X
88148	CYTPATH C/VAG AUTO RESCREEN		X
88152	CYTOPATH CERV/VAG AUTO		X
88153	CYTPATH C/VAG REDO		X
88154	CYTPATH C/VAG SELECT		X
88155	CYTOPATH,(PAP);W/ DEF.HORMONAL EVAL		X
88160	CYTOPATHOLOGY		X
88161	CYTOPATH . . .; PREP, SCREEN INTERP.		X
88162	CYTOPATH . . .; EXT. STUDY.+5 SLIDES, MULTI		X
88164	CYTPATH TBS C/VAG MANUAL		X
88165	CYTPATH TBS C/VAG REDO		X
88166	CYTPATH TBS C/VAG AUTO REDO		X
88167	CYTPATH TBS C/VAG SELECT		X
88173	FINE NEEDLE ASPIRATE..;INTERP/REPORT		X
88174	CYTOPATH, C/VAG (ANY REP.SYSTEM)		X
88175	CYTOPATHOLOGY WITH SCREENING		X
88300	SURGICAL PATHOLOGY, GROSS		X
88302	SURGICAL PATHOLOGY, COMPLETE		X
90772	THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION		X
93000	ROUTINE ECG W/AT LEAST 12 LEADS (only for routine pre-operative sterilization procedures)		X
99000	HANDLING AND/OR CONVEYANCE OF SPECIMEN FOR TRANSFER FROM PHYSICIAN OFFICE TO LAB		X
99201	OFFICE,NEW,PROBLEM, STRAIGHTFORWARD		X
99202	OFFICE,NEW PT,EXPANDED,STRAIGHTFORWARD		X

99203	OFFICE,NEW PT, DETAILED, LOW COMPLEX		X
99204	OFFICE,NEW PT, COMPREHEN, MOD COMPLX		X
99205	OFFICE,NEW PT, COMPREHEN, HIGH COMPX		X
99211	OFFICE, EST PT, MINIMAL PROBLEMS		X
99212	OFFICE,EST PT, PROBLEM,STRAITFORWD		X
99213	OFFICE, EST PT, EXPANDED, LOW COMPLX		X
99214	OFFICE,EST PT, DETAILED, MOD COMPLX		X
99215	OFFICE,EST PT, COMPREHEN,HIGH COMPLX		X
99241	OFF CONSULT,NEW OR EST. PT,PRBLM,STRTFWD		X
99242	OFF CONSLT,NEW OR EST. PT,XPND PBLM, STRTFWD		X
99243	OFF CNSLT,NEW OR EST. PT,DTLD, LO CMPLXY		X
99244	OFF CNSLT,NEW OR EST. PT,CMPHSV,MOD CMPLXY		X
99245	OFF CNSLT,NEW OR EST. PT,CMPHSV,HI CMPLXY		X
99395	PERIODIC COMPREHENSIVE MEDICINE VISIT-EST. PT; 18-39 YRS. OLD		X
A4261	CONTRACEPTIVE SUPPLY	X	
A4266	DIAPHRAGM FOR CONTRACEPTIVE USE	X	
A4267	CONTRACEPTIVE SUPPLY	X	
A4268	CONTRACEPTIVE SUPPLY	X	
A4269	CONTRACEPTIVE SUPPLY	X	
J1055	DEPO-PROVERA INJ 150MG	X	
J1056	LUNELLE MONTHLY CONTRACEPTION INJ	X	
J3490	UNCLASSIFIED DRUG (USE FOR IMPLANON)	X	
J7300	INTRAUTERINE COPPER CONTRACEPTIVE	X	
J7302	MIRENA	X	
J7303	CONTRACEPTIVE SUPPLY	X	
J7304	CONTRACEPTIVE SUPPLY	X	
Q0091	SCREENING PAPANICOLAOU (PAP) SMEAR		X
Q0111	SCREENING PAP SMEAR		X
Q0112	POTASSIUM MYDROXIDE PREPARATIONS		X
T1002	RN SERVICES		X
	CONTRACEPTIVE DRUGS, SUPPLIES, AND ITEMS IDENTIFIED WITH A NDC CODE	X	

Attachment D - AHCCCS Disproportionate Share Hospital (DSH) Payments

Background

Section 1923 of the Social Security Act sets forth Federal requirements designed to aid hospitals that serve a disproportionate share of low-income, uninsured, and Medicaid patients. Federal requirements specify the following minimum standards for determining which hospitals qualify for disproportionate share:

- Those hospitals whose mean Medicaid Utilization Rate exceeds the State's mean Medicaid Utilization Rate plus one standard deviation; or
- Those hospitals whose Low Income Utilization Rate is more than 25 percent.

In addition, beginning in fiscal year (FY) 1996, the Omnibus Budget Reconciliation Act of 1993 (OBRA 93) added the requirement that a hospital must have a Medicaid Utilization Rate of at least 1 percent in order to be eligible for a disproportionate share payment.

A hospital's Medicaid Utilization Rate is the number of inpatient days that were paid for by title XIX Medical Assistance divided by the total number of the hospital's inpatient days. Because Medicaid is not the primary payer, days associated with Medicare crossover claims and encounters are not included.

$$\textit{Medicaid Utilization} = \frac{\textit{Title XIX Days}}{\textit{All Payor Days}}$$

The Low Income Utilization Rate is the sum of the ratio of the total AHCCCS revenues (e.g., Medicaid, Medicare Crossovers, Medically Needy/Medically Indigent (MN/MI) and Eligible Assistance Children/Eligible Low-Income Children (EAC/ELIC); excluding title XXI) and county and state subsidies to net inpatient revenues plus the ratio of gross charity care revenue to gross patient revenues. (Note: MN/MI, EAC/ELIC will not be used for calculations after FY 04.) For county facilities, net inpatient revenues include county subsidy payments. The Low Income Utilization Rate is calculated as follows:

$$\textit{Low Income Utilization} = \frac{\textit{Total AHCCCS Revenue} + \textit{County \& State Subsidies} + \textit{Other Gov't Revenue}}{\textit{Net Inpatient Revenue} + \textit{Other Gov't Revenue}} + \frac{\textit{Gross Charity Revenue}}{\textit{GrossPatient Revenue}}$$

States are allowed to establish disproportionate share criteria that differ from the Federal requirements, but State-specific criteria must be at least as generous as the Federal standards. AHCCCS first implemented a disproportionate share program in FY 1992. Arizona uses State-specific criteria as allowed under the law to provide for a distinction between public and private hospitals, and to create a third private hospital group. Each year a pool of funds is established for disproportionate share payments to hospitals. This pool is apportioned to hospitals that qualify either under the Federal criteria or under the State's criteria based on a relative weighting.

AHCCCS worked with CMS on the DSH methodology in 1991/1992; this methodology has not changed since then. Arizona's DSH criteria established 3 private hospital distribution pools and 1 public hospital distribution pool, the eligibility criteria for these pools has not changed since 1992. Two of these pools are "mandatory Federal DSH pools", and the other 2 are "optional State defined DSH pools." AHCCCS reviews the processes, and the specific financial and utilization data used in the calculations on an annual basis when the DSH payments are calculated and distributed.

In addition, OBRA 93 established rules limiting the total disproportionate share payment that a hospital can receive. Disproportionate share payments are limited to no more than the cost of providing hospital services to patients who are either eligible for medical assistance under a State plan or have no health insurance for the services provided, less payments received under title XIX (other than DSH payment adjustments). These limits went into effect in FY 1995 for public hospitals, and in FY 1996 for private hospitals.

Qualifying Criteria

A hospital in Arizona may qualify for disproportionate share payments by meeting one of two federally mandated criteria or one of two optional, State-specific criteria. One group was established for each of the four criteria. If a hospital qualifies for more than one group, the hospital is categorized into the group that maximizes its disproportionate share payment.

The qualifying criteria for each of the four groups are described below:

Group 1 This group is based on the federally mandated criterion of the State's mean Medicaid (title XIX) Utilization Rate plus one standard deviation. The Medicaid Utilization Rate is defined as a hospital's Medicaid inpatient hospital days divided by the hospital's total inpatient hospital days.

Group 2 This group is based on the federally mandated criterion targeting those hospitals whose Low Income Utilization Rate is more than 25 percent. The Low Income Utilization Rate is defined as the sum of the two fractions: 1) a hospital's low-income revenue (total AHCCCS, State and county revenues) as a percentage of net inpatient revenue, and 2) the percentage that gross charity care revenue contributes to gross hospital revenue.

Group 3 This group is one of the State's optional groups. Acute care general hospitals (psychiatric and rehabilitation facilities excluded) qualify if **either**

1. Their Low Income Utilization Rate is greater than the statewide mean Low Income Utilization Rate, **or,**

2. They provide at least 1.0 percent of the total Medicaid days across hospitals in the State.

Because Group 3 criteria are less restrictive than the criteria for either Group 1 or Group 2, all hospitals that qualify for either Group 1 or Group 2 will also qualify for Group 3. As mentioned above, the actual group placement for a hospital is determined by which placement results in the highest payment.

Group 4 This group is also one of the State's optional groups and consists only of one State and one county hospital (Maricopa Medical Center and Arizona State Hospital).

The Medicaid Utilization Rate and Low Income Utilization Rate for each hospital are based on data from each hospital's Uniform Accounting Report (UAR) and AHCCCS claims and encounter data for each hospital's fiscal year end from 2 years prior (most recently available information). The UAR is an annual financial report, which is mandated by statute and filed with the ADHS. The sources for specific data elements used in the calculations for Groups 1 through 3 are described below.

Medicaid Utilization Rate *(Group 1)*

Total Title XIX Days	Calculated from claims and encounter data plus CRS days.
All Payer Days	UAR

Low Income Utilization Rate *(Groups 2 and 3A)*

Charity Care Revenue	UAR
Gross Patient Revenue	UAR
Net Inpatient Revenue	Calculated from UAR data.
Total AHCCCS Revenue	Calculated from claims and encounter data (excludes Title XXI).
County Revenue	Provided separately by the county facilities.
Other Government Revenue	CRS plus Other Revenues obtained from DHS.

Total AHCCCS Revenue is the sum of the payments for title XIX, MN/MI, EAC, and ELIC claims and encounters; graduate medical education; and supplemental Critical Access Hospital (CAH) payments, as appropriate. (Note, MN/MI, EAC and ELIC will not be used for calculations after FY 04.)

Statewide Percentage of Title XIX Days *(Group 3B)*

Total Title XIX Days	Calculated from claims and encounters (same calculation as for Medicaid Utilization Rate).
Sum of Total Title XIX Days	The sum of all Total title XIX Days from all hospitals that could potentially qualify.

Group 4 consists of all public hospitals. Additional calculations are not required to determine whether the facility qualifies.

A facility must also be Medicare-certified (or Medicare certifiable) on the date the DSH payment is made to be eligible to receive its full DSH payment. If a facility is Medicare-certified for the full Federal fiscal year for which DSH payments are made but lost that certification after the start of the next fiscal year, that facility is eligible for its full DSH payment provided that DSH payments have been finalized prior to the loss of certification. This is true even if AHCCCS has not yet mailed the payment to the hospital.

If a facility that is eligible for a DSH payment changes ownership, the DSH payment will be distributed to the entity that owns the facility at the end of the Federal fiscal year for which the payment is made, assuming that the facility continues to provide services to the same populations it served prior to the change of ownership through the end of the Federal fiscal year for which the DSH payment is made. Facilities should consider this information when negotiating ownership changes.

Disproportionate Share Payments

The DSH funds are allocated to four pools, three private and one public facility pool. The private hospital pool totals are set by AHCCCS as authorized by the Arizona Legislature. AHCCCS reserves the right to reallocate monies within a pool, across the private pools, or both for any reason. In addition, in the event that litigation requires AHCCCS to reimburse a facility, or facilities, the settlement will result in a reallocation of monies such that the current DSH allotment is not exceeded. The amount that each hospital receives from the pool for which they qualify is determined by a weighting method that considers both the amounts or points over the threshold and volume of services, which, depending upon the group classification of the facility, is either measured by title XIX days or net inpatient revenue.

The minimum payment amount for private facilities qualifying for DSH is $5,000.

To determine the allocation for the public acute care hospital, the relative allocation percentage for each hospital is computed under each of the qualifying criteria for the three private groups using Medicaid Utilization Rate, Low Income Utilization Rate, and Percentage of Statewide Medicaid Days. The average of these percentages is used to compute the final allocation for each hospital, not to exceed the OBRA 93 limit for each hospital. The allocations are also made in accordance with the levels determined by the Arizona Legislature. The Arizona State Hospital is limited by the Federal IMD payment limits.

OBRA 93 Payment Limits

As discussed previously, OBRA 93 contains provisions that affect the qualification of DSHs and the amount of payment. The qualification change is that for State fiscal years beginning in 1994, a facility may not be qualified as a DSH facility unless it has a Medicaid Utilization Rate of at least 1 percent.

Another provision of OBRA 93 is that a hospital's DSH payment must be limited to the difference between the cost of providing services to the uninsured and the Medicaid payments received. In FY 1995 this applied only to public facilities, but beginning in FY 1996 this limit

applied to both public and private facilities. AHCCCS will calculate the OBRA 93 limits for public hospitals pursuant to the Benefits Improvement Protection Act of 2000, section 701(c) for payments beginning FY04 and FY05.

As the final step in the DSH payment calculation methodology, the payment's proportion of the OBRA 93 limit is calculated as the ratio of the unadjusted DSH payment to the total cost of low-income care less Medicaid payments:

$$\frac{\textit{unadjusted DSH payment}}{\textit{cost of low income care} \;-\; \textit{Title XIX payment}}$$

The facility's cost of low-income care is the sum of the cost of services to Medicaid patients and the cost of services to uninsured patients, including unreimbursed graduate medical education costs. The proportion must be one or less than one for facilities to be in compliance with the OBRA 93 provision.

The cost of low-income care is calculated using the claims and encounter data submitted by each facility as well as hospital-specific cost-to-charge ratios, and Medicare Cost Report data. The total cost includes the costs of the following components: title XIX, MN/MI, EAC, ELIC, charity care, and county and other government payments. (Note: MN/MI, EAC and ELIC will not be used for calculations after FY 04.)

The cost of low-income care for public hospitals also includes the professional component of expenses, which is eliminated from inpatient expenses as a section A-8 adjustment on the Medicare Cost Reports.

Hospitals are determined to be ineligible for DSH payments if their total title XIX payment exceeds their cost of care (i.e., their costs of providing low income care have been fully reimbursed.)